

074800 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34380

1. DECEASED NAME (TYPE OR PRINT) IRENE HARRIS BENNETT		2a. DATE OF DEATH MONTH DAY YEAR 12:06:87		2b. HOUR 2:35 PM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 9 3 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL HOSP.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME		12c. BALTO. MD. 21215	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE WARFIELD HARRIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE KENNARD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-40-4377		17. INFORMANT MRS. BALTIMORE, MD. 21215 VERA FLINT 3512 WHITE CHAPEL ROAD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bladder urinary carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic primary bladder cancer DUE TO, OR AS A CONSEQUENCE OF (c) hypertension					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes mellitus Cerebrovascular accident					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/25/1987 , to 12/6/1987 , that (I) (we) last saw the deceased alive on 12/6/1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]		22e. ADDRESS North Charles Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/10/1987		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.		23e. DATE REC'D. BY REGISTRAR DEC 11 1987			
24. FUNERAL DIRECTOR NAME ADDRESS NUTER FUNERAL HOMES INC.		25. REGISTRAR'S SIGNATURE [Signature]			

054860-208150

075506 DEC 18 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FUNERAL HOME'S CERTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 132 per phone FAX STATE OF MARYLAND
FOR
1- STATE REGISTRAR
12/21/87 DAB

075506 DEC 18 87

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4381

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
James Arthur Bennett III						2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.		
MALE			BLACK			10-21-60			27 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
BALTO., MD.			USA						Baltimore City			MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			University Hospital			STORE MANAGER			BAKERY					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MARYLAND			BALTIMORE			BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1304 THE ALAMEDA W. 1236 W. 1st Ave		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST			FIRST MIDDLE LAST											
JAMES A. BENNETT II			FRANCES VANNA GIBSON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
YES			1979			219-74-0698			FRANCES WHITE			2315 HARMAN 21230		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Asphyxia</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) _____														
DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
Depressive illness														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-14-87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
								Stuffed shirt in mouth						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)				21f. LOCATION						
				Institution				Walter P. Carter Center, 630 W. Fayette St., Baltimore City, MD						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
Charles P. Kokes, M.D.				M.D. Assistant				MEDICAL EXAMINER				12-15-87		
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
Charles P. Kokes, M.D.				111 Penn Street, Baltimore, MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				
BURIAL				12-19-87		GARRISON FOREST VETERAN				BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
BROWN/THOMPSON FUNERAL HOME				P.O. BOX 4433				DEC 17 1987				Julia Davidson-Randall		

07/84
25MBP
DHMH - 17
(VR A15 ME (15))

DEC 11 1958

074580 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove copies of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34382

1. FOR
STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Florence A. Bennett</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 05 87</i>			2b. HOUR 10 ⁵⁵ _{AM}	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR <i>SEPT 29 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>86</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) <i>Mercy Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY BOWLING ALLEY	
13a. STATE MD.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. GREY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE HOLLAND		13e. STREET ADDRESS / ZIP CODE 2225 Lincoln Ave. 21219			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-01-4052		17. INFORMANT ADDRESS EMMA M. HARDESTY (DGHTR) SAME ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>Diabetes Mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>years</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Dehydration, hypernatremia, ASCVD, history of CVA</i>							
19a. DATE OF OPERATION <i>12/5</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/4</i> , 19 <i>87</i> , to <i>12/5</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>12/5</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>N. W. Todd, MD</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>12/5/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Nervins W. Todd, M.D.</i>				22e. ADDRESS <i>301 St. Paul Place Balt MD 21202</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/8/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE MD.	
24. FUNERAL DIRECTOR SCHMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR DEC - 8 1987		25b. REGISTRAR'S SIGNATURE <i>Frederick R. ...</i>	

BP

706-550-6824 x0

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4383

1- FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE KNOWN OF DEATH		21. HOUR	
Jennie Lee Bennett		XX MONTH DAY YEAR 12-26 19 87		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Female	White	Aug. 7, 1908	79 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Tennessee	USA			Baltimore City, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	1450 Battery Avenue Balto. Md.	Homemaker			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	---	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21230 1450 Battery Ave. Balto. Md.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST J.B. Presley Barn	FIRST MIDDLE LAST Mae Presley Barn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
No	413-05-4813	Mr. William A. Bennett, Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Mario F. Golle, Jr., M.D.		Assistant		12-28-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Mario F. Golle, Jr., M.D.		111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	12/30/87	New Gray Cemetery	Knoxville, Knox Co. Tenn.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.		DEC 29 1987		J. B. Burden-Hendall	

7 0 1 0 0 1 0 0 0 5

20% COTTON FIBER

DAVID WHITEHEAD



DEC 3 8 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one of the following:

DHMH-16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1- STATE
REGISTRAR

87 REG. NO. 34384

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CARRIE		BERGHEIMER		DEC. 5, 1987		6:15 A _M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	WHITE	NOV. 16 th , 1903 rd		84		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
NEW YORK	USA			BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	BALTIMORE COUNTY GEN. HOSP.			HOUSEWIFE		AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5250 PIMLICO RD. #21215	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
HARRY MIDDLE LINHARDT		PAULA MIDDLE HECHTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			
NO		112-058380		EMANUEL LINHARDT 50 E. 42nd ST., NEW YORK, NY 10017			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA (probable)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ADVANCED ARTERIOSCLEROSIS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> 19 <u>87</u> to <u>DEC 5</u> 19 <u>87</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on above, (I) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
<u>Ian Sunshine, M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>12/5/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
IAN SUNSHINE, M.D.		6210 PARK HTS. AVE. BALTO., MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		DEC. 7, 1987		CHEVRA AHAVAS CHESED		RANDALLSTOWN BALTO., MD STATE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD		DEC 10 1987		<u>Julia Anderson-Randall</u>			

BP

04157 15250

77269 JAN - 68

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34385
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Cunigunda LAST Berry			2a. DATE OF DEATH MONTH DAY YEAR 12 30 87			2b. HOUR 1:25 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 05 07		6. AGE (IN YEARS (LAST BIRTHDAY)) 80	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Villa St. Michael Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Housework	
13a. STATE Md.			13b. CITY OR TOWN Essex		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST Andrew MIDDLE Foehrkolb LAST			15. MOTHER'S MAIDEN NAME FIRST Dora MIDDLE Addicks LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-18-9708		17. INFORMANT ADDRESS Andrew Foehrkolb 1129 Engleberth Rd. 21221			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1c							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 5-11, 1985, to 12-30, 1987, that (I) (we) last saw the deceased alive on Dec 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harold B. Bob MD				DEGREE MD		22c. DATE SIGNED 12-31-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B. Bob MD				22e. ADDRESS 7220 Park Heights 21208			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-02-88		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. ADDRESS 901 S. Conkling St.				25a. DATE REC'D. BY REGISTRAR JAN 5 1988		25b. REGISTRAR'S SIGNATURE John E. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit requires the funeral director to sign and give the permit to the State Dept. of Health and Mental Hygiene prior to the removal of the body for burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or trauma, a traumatic event, the medical examiner may be notified.

BP

1:25

02

07

02

01

White

Female

U.S.A.

xx

U.S.A.

Female

U.S.A.

U.S.A.

U.S.A.

Female

U.S.A.

xx

U.S.A.

Female

U.S.A.

xx

U.S.A.

Female

U.S.A.

U.S.A.

U.S.A.

Female

U.S.A.

U.S.A.

U.S.A.

076596 DEC 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate is required for the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR	
		ERNEST		LEON		BESS		DECEMBER 23, 1987		7:50A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		BLACK		5 5 1949		38 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U. S. A.				BALTIMORE CITY				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		SOCIAL WORKER		DEPT. SOC. SER.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS	
		MARYLAND				BALTIMORE				BALTIMORE, MD.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
ALEX		NEAL		SARAH		EVA		BESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO.		230-66-5258		MRS. SARAH E. BESS		BALTIMORE, MD.				1828 EUTAW PLACE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UPPER GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (b) DEHYDRATION DUE TO, OR AS A CONSEQUENCE OF (c) ACQUIRED IMMUNODEFICIENCY SYNDROME										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 2 WEEKS 1 YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIARRHEA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 18, 19 87, to DECEMBER 23, 19 87, that (I) (we) lost saw the deceased alive on DECEMBER 23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
Lois E. Nielsen MD						12-23-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
LOIS E. NIELSEN MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		12/29/1987		ARBUTUS MGN. PK.		BALTIMORE, MD.					
24. FUNERAL HOME		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
WATER FUNERAL HOMES, INC.		DEC 29 1987									
2501 GWYNNS FALLS PKWY, BALTO, MD. 21216											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Morris Betz					2a. DATE OF DEATH MONTH DAY YEAR 12 13 87					2b. HOUR 8:36 PM
3. SEX M	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12 12 1896			6. AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deputy Director		12b. KIND OF BUSINESS OR INDUSTRY U.S. Customs			
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2830 Pelham Avenue -21213		
14. FATHER'S NAME FIRST MIDDLE LAST John Betz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Liddard								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT Gordon M. Betz - 8114 Rider Ave. -21204						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aortic Stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14/87</u> to <u>12/17/87</u> , that (I) (we) last saw the deceased alive on <u>12/17/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MELKON HAJINAZARIAN					22e. ADDRESS Good Samaritan Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-16-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME John C. Miller, Inc. -6415 Belair Road-21206					25a. DATE REC'D. BY REGISTRAR DEC 13 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

1051515

1051515

1051515

076564 DEC 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34388

1- FOR
STATE
REGISTRAR

DECEASED NAME

FIRST MIDDLE LAST

EMMANUEL

BEVERLY

2a DATE OF DEATH MONTH DAY YEAR 12 25 87 2b HOUR 325A M

3. SEX

m

4 RACE

B 2

5. DATE OF BIRTH

MONTH DAY YEAR 4 30 11

6 AGE (IN YEARS LAST BIRTHDAY)

76

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD

7b CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY MD.

10 CITY OR TOWN OF DEATH

BALTIMORE CITY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

LIBERTY MEDICAL CENTER

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b KIND OF BUSINESS OR INDUSTRY

HochschildKohn

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD

13b COUNTY

13c CITY OR TOWN

BRITO.

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

1619 N. Fulton Ave 21217

14. FATHER'S NAME

FIRST MIDDLE LAST

Joseph

Perry

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST

Frances E. Beverly

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

212-12-7220

17 INFORMANT

Gladys Beverly

ADDRESS

1619 N. Fulton Ave

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Bilateral Pneumonia, Lung Metastasis

DUE TO, OR AS A CONSEQUENCE OF

(c) CARCINOMA COLON

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 12-08-1987 to 12-25-1987 that (I) (we) lost saw the deceased alive on 12-25-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

SHER A Hashmi

DEGREE

MD

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c DATE SIGNED

12-25-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

SHER A HASHMI

22e ADDRESS

2600 LIBERTY HEIGHTS AVE 21215

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

12/31/87

23c NAME OF CEMETERY OR CREMATORY

Garrison Forest Vet

23d LOCATION CITY OR TOWN COUNTY STATE

Owings Mills, Md.

24 FUNERAL DIRECTOR

NAME

Wm C March F/H West

ADDRESS

4300 Wabash Ave.

25a DATE REC'D. BY REGISTRAR

DEC 29 1987

25b REGISTRAR'S SIGNATURE

Julia Davidson-Randall

100-101130-100

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to fading and bleed-through from the reverse side of the page. It appears to be a memorandum or letter containing several paragraphs of text.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autopsify.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FERN ELIZABETH BIGGS					2a. DATE OF DEATH MONTH DAY YEAR 12-2-87					2b. HOUR 11:30 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 10 43			6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) INNS OF EVERGREEN - South			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 200 E. Fort Ave 21230			
14. FATHER'S NAME FIRST MIDDLE LAST Charles I. Gude				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fern Estelle Reddish							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-40-9580		17. INFORMANT ADDRESS Russell E. Biggs, 135 W. Ostend St. 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postoperative Huntington's Chorea DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/2 19 87 , to 12/2 19 87 , that (I) (we) last saw the deceased alive on 12/2 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]						DEGREE			22c. DATE SIGNED 12/3/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OH						22e. ADDRESS Mary Way					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/4/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemt.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A. Co. Martland			
24. FUNERAL DIRECTOR NAME ADDRESS Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.						25a. DATE REC'D. BY REGISTRAR DEC - 7 1987			25b. REGISTRAR'S SIGNATURE [Signature]		

BP

071305 DEC-887

1988 12-27

11

12

13

14

15

16



1988 12-27

17

18

19

20

21

22

Handwritten signature

1988 12-27

1988 12-27

Handwritten signature

Handwritten signature

DEC-7 1988

75118 DEC 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34390

1. DECEASED NAME (TYPE OR PRINT) ANTONIO Charles BIONDO			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 12, 1987		2b. HOUR 8:32 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 18 1899		6. AGE (IN YEARS (LAST BIRTHDAY)) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED	12b. KIND OF BUSINESS OR INDUSTRY BARBER	
13a. STATE MD.	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3031 MAYFIELD AVE. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES BIONDO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CONCETTA CATALANO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-34-9032	17. INFORMANT ADDRESS MARY BIONDO -- SAME ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure, Cardiac</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mult. organ Failure (Renal, Cardiac)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dissecting Aortic Aneurysm</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 48 hours 48 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/10/87</u> 19 <u>87</u> to <u>12/12/87</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/12/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard P. ...</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. ...		22e. ADDRESS 21205 JH # 600 N. WOLFE ST. BALTO., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/15/87	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		
24. FUNERAL DIRECTOR SCHMUNEK FUNERAL HOME, INC.		3331 Brehms Lane Baltimore, Md. 21213	25a. DATE REC'D. BY REGISTRAR DEC 15 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. They must remove carbon papers, pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows city injury, or other traumatic event, and if local examiner must be notified at once.

BP

12110001

SECRET

2 2 11 2

7

CONFIDENTIAL

CONFIDENTIAL

SECRET

MD

12110001

075000 DEC 15

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. <u>343791</u>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>CAROLINE Ruth BISSE</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>12/11</u> <u>5/4/1939</u> <u>11.50pm</u>									
3. SEX <u>Female</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>5/4/1939</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>48</u> YRS. <table border="1"><tr><td colspan="2">IF UNDER 1 YEAR</td><td colspan="2">IF UNDER 24 HRS</td></tr><tr><td>MONTHS</td><td>DAYS</td><td>HOURS</td><td>MIN.</td></tr></table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		MONTHS	DAYS	HOURS	MIN.
IF UNDER 1 YEAR		IF UNDER 24 HRS											
MONTHS	DAYS	HOURS	MIN.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.									
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Saint Agnes Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife & Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u></u> 13c. CITY OR TOWN <u>Baltimore</u>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <u>4610 Virginia Ave., 21225</u>									
14. FATHER'S NAME FIRST MIDDLE LAST <u>John Fousek</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Alma</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>213-36-3065</u>		17. INFORMANT ADDRESS <u>Donald G. Bisser Same as #13</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest (Aystole)</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Multiple organ failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5:00 minutes</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>ARDS, overwhelming sepsis, liver failure, renal failure Anemia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <u>STREET</u>									
22a. I certify that (I) (this hospital) attended the deceased from <u>10/31/1985</u> to <u>12/11/1987</u> , that (I) (we) last saw the deceased alive on <u>12/11/1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>12/11/87</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NITIN MAYUR</u>		22e. ADDRESS <u>ST AGNES HOSPITAL</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/15/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery Balto., A.A. Co., Md.</u>									
24. FUNERAL DIRECTOR NAME <u>McCully Funeral Homes Balto., Md. 21225</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO., A.A. Co., Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 14 1987</u>									
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

1924

01200-000370

1924-1-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34392

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR MIN.	
Marie O. Bitter		12 25 87		9:28 A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	62 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Church Hospital	Lathe Operator	Machine Shop		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1931 Barry Rd 21222	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
George F. Bitter	Matilda F. Koop	16b. SOCIAL SECURITY NO. 217-12-6968			
17. INFORMANT		17. ADDRESS			
Ann Stevens Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CA Lung, CMF					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION (CITY OR TOWN, COUNTY, STATE)			
WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Beema Nagpal					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
B. Nagpal, M.D.		Church Hospital			
100N. Broadway, Baltimore, Md, 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN, COUNTY, STATE)		
Burial	12-28-87	Most Holy Redeemer	Baltimore Maryland		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Duda-Ruck Funeral Home of Dundalk		DEC 30 1987			
7922 Wise Ave Dundalk, Md. 21222					

074539 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 101.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 4 3 9 3			
1- FOR STATE REGISTRAR DECEASED NAME FIRST MIDDLE LAST Vernal Ray Blackburn										2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12/ 5/ 19 87		2b. HOUR 2:49 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 26, 1941		6. AGE (IN YEARS) (LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12/ 5/ 19 87		24 HOUR P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD							
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Credit Manager		12b. KIND OF BUSINESS OR INDUSTRY Financial					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1849 John Drive 21040					
14. FATHER'S NAME FIRST MIDDLE LAST Tracy Worth Blackburn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grady (nmn) Phillips				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --				17. INFORMANT Aberdeen, Md. 21001 T.Scott Blackburn, 811 Shirley Drive,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8129 Head Injuries IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:15xx 12/ 5/ 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) bicyclist struck by auto							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21i. LOCATION CITY OR TOWN Calvery Rd., COUNTY Harford, STATE Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Dennis F. Smyth M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 12/6/87					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 8, 1987		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Baptist Cemetery, Bel Air				23d. LOCATION CITY OR TOWN Harford COUNTY STATE Md.					
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR DEC - 8 1987		25b. REGISTRAR'S SIGNATURE John Swickard							

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

100-330 8-320

100-330 8-320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8734394

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Janie H. Blackmore			2a. DATE OF DEATH MONTH DAY YEAR 12 14 1987		2b. HOUR M
3. SEX female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 25 1910	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3800 W. Belvedere Apt 201		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3800 W. Belvedere 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Henley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmira Henley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-22-6092	17. INFORMANT ADDRESS Aurelia Bell 6424 Craigmont Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Congestive Heart Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> 19 <u>85</u> to <u>12/14</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>12/1</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>M. R. Berman</u>		DEGREE MD		22c. DATE SIGNED 12/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. R. Berman MD		22e. ADDRESS 2717 HAMMONDS FERRY RD BALTIMORE 21227			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/87	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue			25a. DATE REC'D. BY REGISTRAR DEC 17 1987		
			25b. REGISTRAR'S SIGNATURE <u>Robert A. Hurd</u>		

05250

DEC 13 1987

076019 DEC 23 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8734395
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CARRIE BLACKWELL			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 18, 1987		2b. HOUR 2:05P M
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 2 01		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1915 CASTLE STREET 21213
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-16-3432	17. INFORMANT ADDRESS DOLORES JENKINS 2003 SINCLAIR LANE 21213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/5, 19 87, to 12/17, 19 87, that (I) (we) lost saw the deceased alive on 12/17, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kathy Bull-Henry, M.D.		DEGREE M.D.		22c. DATE SIGNED 12/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kathy Bull-Henry		22e. ADDRESS 1000 East Eager Street, Balt. Md. 21202			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 12/22/87	23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE		25a. DATE REC'D. BY REGISTRAR DEC 22 1987		25b. REGISTRAR'S SIGNATURE Julia E. ...	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON MED DR. D. SMYTH PER MR. RICHARDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

ANNUAL REPORT OF THE SECRETARY

1908

74009 DEC -3 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34396

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN E. BLAKE			2a. DATE OF DEATH MONTH DAY YEAR 12/2/87		2b. HOUR 540 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 20, 1901		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Home		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE MD		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		
14. FATHER'S NAME FIRST MIDDLE LAST Seth E. Everett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Long		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220 44 2696		17. INFORMANT ADDRESS Edward F. Blake, Jr., 21204		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Sepsis and dehydration DUE TO, OR AS A CONSEQUENCE OF (b) - Bowel obstruction DUE TO, OR AS A CONSEQUENCE OF (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 week						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 19 86, to Dec 2, 19 87, that (I) (we) last saw the deceased alive on Dec 2, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature] M.D.				22d. DATE SIGNED 2 Dec 1987		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/4/87		23c. NAME OF CEMETERY OR CREMATORY Confederate Cem.		
24. FUNERAL DIRECTOR NAME H. W. Jenkins & Sons Co.		23d. LOCATION CITY OR TOWN COUNTY STATE Fredericksburg, VA		23e. ADDRESS Keswick		
25. DATE REC'D BY REGISTRAR DEC 03 1987						
26. REGISTRAR'S SIGNATURE [Signature]						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

74000 DEC-30

208 COTTON FIBER

CHIEF TAIL FLOW

Handwritten notes and signatures are present throughout the page, including a large signature in the center and various smaller notes and initials.

076002 DEC 23 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34397

1. DECEASED NAME (TYPE OR PRINT) BELLA LORRAINE BLOCHER			2a. DATE OF DEATH MONTH: 12 DAY: 20 YEAR: 87		2b. HOUR 1 A.M.	
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH: Jan. DAY: 29 YEAR: 1924		6. AGE (IN YEARS LAST BIRTHDAY) 63	7. IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.	
16. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	17. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE PA	13b. COUNTY Salisbury	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE RD 1, 15558 99999		

14. FATHER'S NAME FIRST: Dewey MIDDLE: Brenneman LAST: Skidmore		15. MOTHER'S MAIDEN NAME FIRST: Glennie MIDDLE: M. LAST: Skidmore	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 218 16 2948	17. INFORMANT ADDRESS Thomas Funeral Home, Salisbury, PA	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>12/20</u> , 19 <u>87</u> , to <u>12/20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <u>Willie TSE MD</u>	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-20-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. TSE MD		22e. ADDRESS FSK Hospital, EASTERN AVE BALTO MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial	23b. DATE 12-20-87	23c. NAME OF CEMETERY OR CREMATORY Salisbury Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, PA
24. FUNERAL DIRECTOR NAME Henry W Jenkins & Sons		25a. DATE REC'D. BY REGISTRAR DEC 22 1987	25b. REGISTRAR'S SIGNATURE <u>John D. R. R. R.</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH 16 60M 7/84
(VRA 15, 4)

130250 502850

20% COTTON CURE

CHILDREN'S



074358 DEC-87

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34398

2. DECEASED NAME (TYPE OR PRINT) Katherine BODNAR			2a. DATE OF DEATH MONTH DAY YEAR 12 2 87		2b. HOUR 11 ³⁷ PM
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Mar. 19 17	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Lansdowne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles Kowalczyk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 216-12-6808	17. INFORMANT John Bodnar, Sr., 3003 Georgia Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Multiple sources of infection from</u> (c) <u>Wounds arms, urine & abdominal wound</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours day 3
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>End stage renal disease on hemodialysis: Shothowel from ischemic bowel</u>					
19a. DATE OF OPERATION 11/4/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ischemic bowel	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13/87</u> , 19 <u>87</u> , to <u>12/2</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/2/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Shaker MD	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAKA 22 MD	22e. ADDRESS 7231 Ritchie Highway Glenburne				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/7/87	23c. NAME OF CEMETERY OR CREMATORY St. Michaels Ukrainian	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR HUBBARD Hubbard Funeral Home, Inc., 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC-7 1987	25b. REGISTRAR'S SIGNATURE John Bodnar Sr.		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

PLATE 100

100-100-100

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "plate" and "number" are faintly visible.]

074477 DEC 9 87

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34399

3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 8 - 30 - 1919			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.			7a. DATE OF DEATH MONTH DAY YEAR December 3, 1987			7b. HOUR 9:30 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD								
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Medical Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Exxon			12b. KIND OF BUSINESS OR INDUSTRY Crew Leader					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7611 Spruce Rd. 21222		
13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Dundalk,											
14. FATHER'S NAME FIRST MIDDLE LAST Michael Bogucki						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Not Known											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II			17. INFORMANT Veronica Bogucki			ADDRESS Same as 13e								

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio pulmonary arrest

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Non-small cell carcinoma of lung

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

10 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 19 86 to 3 Dec 19 87, that (I) (we) last saw the deceased alive on 13 Nov. 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Morris Rainess				DEGREE MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Morris Rainess				22e. ADDRESS 1105 Old Eastern Ave.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-87		23c. NAME OF CEMETERY OR CREMATORY Sacred Ht Of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk, Inc.				25a. DATE REC'D. BY REGISTRAR DEC 08 1987			
				25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1170



Items, 2a, 5, 6, & 17, G-635, 1/5/88, by F.H. STATE OF MARYLAND

FOR Gbj.
1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34400

1. DECEASED NAME FIRST MIDDLE LAST WILLIAM BOLAR			2a. DATE OF DEATH MONTH DAY YEAR 12 10 87		2b. HOUR 2:40 P.M.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 9 1906		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Baltimore		13a. CITY OR TOWN Baltimore		13b. STREET ADDRESS / ZIP CODE 827 Arlington Ave #104 21211		
14. FATHER'S NAME FIRST MIDDLE LAST Paige Bolar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Green		17. INFORMANT ADDRESS Annie Mae Bolar, 827 Arlington Avenue		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-3863		17. INFORMANT ADDRESS Annie Mae Bolar, 827 Arlington Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia / Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-40 min</u> <u>2-3 days</u> <u>long term</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> 19 <u>87</u> to <u>12/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>				22c. DATE SIGNED <u>12/10/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kovitz</u>				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/14/87		23c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEM.		
23d. LOCATION CITY OR TOWN BALTO., MD.		23e. COUNTY BALTO.		23f. STATE MD.		
24. FUNERAL DIRECTOR LEROY O. DYETT 4600 LIBERTY HEIGHTS AV				25a. DATE REC'D. BY REGISTRAR DEC 15 1987		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



052165 05 1985

052165 05 1985

074018 DEC 3 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34401
REG. NO.

DECEASED NAME (TYPE OR PRINT) SALVATORE BONAVENTURA			2a DATE OF DEATH MONTH DAY YEAR 12-01-87		2b HOUR 0615 P.M.
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 12 06 26	6 AGE (IN YEARS LAST BIRTHDAY) 60	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven VA Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Casino Employee	12b KIND OF BUSINESS OR INDUSTRY Las Vegas	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 131 S. Eaton St. 21224
14 FATHER'S NAME FIRST MIDDLE LAST Luigi BONAVENTURA		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clementina Pelino			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mrs. Tina D'Eugenio 131 S. Eaton St. Baltimore, MD 21224	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lung Cancer (most likely) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 28 November 19 87 to 1 December 19 87 , that (I) (we) last saw the deceased alive on 1 December 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If the deceased did not see the body after death, so state.)					
22b PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey Joe, M.D.		DEGREE MD		22c DATE SIGNED 12-1-87	
22d PHYSICIAN'S ADDRESS 22 S. Greene St., Baltimore, MD 21201		22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b DATE 12-4-87		23c NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	
23d LOCATION (CITY OR TOWN) COUNTY STATE Baltimore, Maryland		24 FUNERAL DIRECTOR NAME ADDRESS Joseph N. ZANNINO JR. 2635 S. Conkling St. Baltimore, MD 21224			
25a DATE REC'D. BY REGISTRAR DEC 03 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the project. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is to determine the effect of temperature on the rate of reaction of hydrogen peroxide with potassium iodate in the presence of a catalyst. The organization of the project is as follows: a general description of the project, a description of the experimental procedure, a description of the results, and a conclusion.

2. The second part of the report is a description of the experimental procedure. It includes the materials, the apparatus, and the procedure. The materials are hydrogen peroxide, potassium iodate, and a catalyst. The apparatus is a reaction vessel, a thermometer, and a stopwatch. The procedure is as follows: a solution of potassium iodate is prepared in a reaction vessel. A solution of hydrogen peroxide is added to the reaction vessel. The reaction is started by adding a catalyst. The time taken for the reaction to complete is measured with a stopwatch. The temperature of the reaction mixture is measured with a thermometer.

3. The third part of the report is a description of the results. It includes the data, the graphs, and the calculations. The data is as follows:

Temperature (°C)	Time taken for reaction to complete (s)
20	120
30	80
40	60
50	45
60	35

The graphs are as follows:

Graph 1: A plot of the natural logarithm of the time taken for the reaction to complete (ln t) against the reciprocal of the absolute temperature (1/T). The plot is a straight line with a negative slope. The equation of the line is $\ln t = -15000/T + 10$.

Graph 2: A plot of the natural logarithm of the rate of reaction (ln k) against the reciprocal of the absolute temperature (1/T). The plot is a straight line with a negative slope. The equation of the line is $\ln k = -15000/T + 10$.

The calculations are as follows:

The activation energy (Ea) of the reaction is determined from the slope of the line in Graph 1. The slope is -15000 K. The activation energy is $E_a = 15000 \times 8.314 \text{ J K}^{-1} \text{ mol}^{-1} = 124710 \text{ J mol}^{-1}$.

The rate constant (k) of the reaction is determined from the equation of the line in Graph 2. The rate constant is $k = e^{10 - 15000/T}$.

4. The fourth part of the report is a conclusion. It includes the summary of the results and the conclusions. The summary of the results is that the rate of reaction of hydrogen peroxide with potassium iodate increases with increasing temperature. The conclusions are that the activation energy of the reaction is 124710 J mol⁻¹ and that the rate constant of the reaction is $k = e^{10 - 15000/T}$.

075453 DEC 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34402

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE BOONE			2a. DATE OF DEATH MONTH DAY YEAR 12 09 87			2b. HOUR 3:05 PM			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 09 29 20		6. AGE (IN YEARS LAST BIRTHDAY) 67		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LMC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Beth Steel			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3003 Clifton AVE 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Boone			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANNIE Vaughan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 218-16-7742		17. INFORMANT McArthur Blower		ADDRESS 5306 Wabash AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE ASPIRATION DUE TO, OR AS A CONSEQUENCE OF (c) ELECTROLYTE IMBALANCE & HYPOKALEMIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DEHYDRATION, ANAEMIA, WEIGHT LOSS, ALCOHOLISM.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-08-1987 to 12-09-1987 , that (I) (we) last saw the deceased alive on 12-09-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sudhir D. Patel				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-09-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUDHIR D. PATEL				22e. ADDRESS LIBERTY MEDICAL CENTER LIBERTY HEIGHTS, BALTIMORE MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/87		23c. NAME OF CEMETERY OR CREMATORY Carver Park		23d. LOCATION CITY OR TOWN COUNTY STATE Murfreeboro, N.C.			
24. FUNERAL DIRECTOR NAME Wm C March F/H West				4300 Wabash Ave.		25a. DATE REC'D BY REGISTRAR DEC 17 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is properly filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

072413 0000

DEC 13 1981

077000 10-10

RECEIVED 10/10/50

TO: Mr. J. Edgar Hoover
FROM: Mr. [illegible]
SUBJECT: [illegible]

DATE: 10/10/50
BY: [illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) Vaughn Wilber Bosson					2a. DATE OF DEATH MONTH DAY YEAR 12-23-87		2b. HOUR 1050 P.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 14 93		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Annapolis, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairmount Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Consolidated Engin		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5501 Wayne Avenue 21207	
14. FATHER'S NAME FIRST MIDDLE LAST John Mitchell Bosson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Royston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-01-5778		17. INFORMANT Mrs. Virginia M. Merkel		ADDRESS 5501 Wayne Avenue Baltimore, MD 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A.R. Norzemi M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/23/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.R. Norzemi, M.D.						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/26/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore MD			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc						25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE John S. ...		
ADDRESS 8728 Liberty Road Randallstown, MD. 21133										

BP

[Faint, illegible text, likely bleed-through from the reverse side of the page]



76891 DEC 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34405

1. DECEASED NAME (TYPE OR PRINT) Beatrice Carr Boughner			2a. DATE OF DEATH MONTH DAY YEAR December 29, 1987		2b. HOUR 845 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 19, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress	12b. KIND OF BUSINESS OR INDUSTRY G.C. Murphy	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Glen Burnie	13c. STREET ADDRESS / ZIP CODE 6656 Sholley Road Apt B4	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Jessie P. Carr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tillie (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA	17. INFORMANT (Son) Raymond L. Baughner		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE			
		DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC CORD			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital)) attended the deceased from 12 Dec 19 87 to 29 Dec 19 87, that (I (we)) last saw the deceased alive on 29 Dec 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we)) (did) (did not) view the body after death.					
22b. SIGNATURE J. Wheeler		DEGREE M.D.		22c. DATE SIGNED 29 Dec 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACQUELYN L WHEELER		22e. ADDRESS 3001 SO HANOVER ST BALT MD 21230			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 5, 1988	23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland
24. FUNERAL DIRECTOR NAME R. H. Hyslop		ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25. DATE REC'D BY REGISTRAR DEC 31 1987	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

50 4 3 2 1

075002 DEC 15 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34406

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANITA A. BOWEN				2a. DATE OF DEATH MONTH DAY YEAR 12 09 87		2b. HOUR 4:07P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 02 23		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1606 PARKMAN AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES GARDNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY REINHART		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 219-12-9754		17. INFORMANT ADDRESS JAMES BOWEN 1606 PARKMAN AVE. BALTIMORE MD 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis from esophageal ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/89</u> , 19 <u>87</u> , to <u>12/9</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>W.C. Waterfield MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/10/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W.C. Waterfield MD</u>				22e. ADDRESS <u>St Agnes Hospital</u> <u>700 Caton Ave Balt. Md 21229</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/11/87		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE DORSEY MARYLAND	
24. FUNERAL DIRECTOR LEREOY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228				25a. DATE REC'D. BY REGISTRAR DEC 14 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

7635

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REC'D. 3 4 4 0 7							
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Delores Bowen										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12/ 20/ 19 87		2b. HOUR 8:31					
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH (MONTH DAY YEAR) AUG. 26, 1946		6. AGE (IN YEARS) (LAST BIRTHDAY) 41		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 12/20/ 19 87		7d. HOUR 8:31					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD				13b. COUNTY BALTO.				13c. CITY OR TOWN BALTO.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1325 W. SATATOGA ST. 21223			
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS JONES								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BROWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 312 48 0727				17. INFORMANT ADDRESS MARY WILLIAMS 2430 W. FRANKLIN ST.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Acquired Immune Deficiency Syndrome DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				DATE (SPECIFY) 12/21/87								DATE SIGNED 12/21/87							
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/23/87				23c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.							
24. FUNERAL DIRECTOR LEROY O. DYETT 4600 LIBERTY HEIGHTS AV				25a. DATE REC'D. BY REGISTRAR DEC 28 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>											

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

100-100-100



100-100-100

100-100-100

1 JAN 2 1968

WALTON

WALTON

WALTON

WALTON

()

WALTON

530 02 JS

WALTON

075696 DEC 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34409

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) Byron L. Bowie		MONTH DAY YEAR 12 16 87		11:00 PM	
3. SEX M	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10 29 1930		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dealer		12b. KIND OF BUSINESS OR INDUSTRY Antiques	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS & ZIP CODE 15125 Lutes Lane 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Lyndon Bowie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kinred			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 006-26-1474		17. INFORMANT ADDRESS Lois Bowie 477 Krams Ave. Philadelphia, PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/29/87</u> 19 <u>87</u> to <u>12/16/87</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>12/16</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MECKON HASINAZARIAN		22e. ADDRESS Good Samaritan Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-19-87		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park Catonsville, Baltimore, MD.	
23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Upperco, MD.		25a. DATE REC'D. BY REGISTRAR DEC 21 1987	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

073850 DEC-31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and cemetery filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34410

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SUSIE E BOWLES			2a. DATE OF DEATH MONTH DAY YEAR 12 1 87		2b. HOUR 6:00 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 1 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph McKay		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Brady		13e. STREET ADDRESS / ZIP CODE 3901 Parkside Drive 21206	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-24-6869		17. INFORMANT ADDRESS Mrs. Mary V. Cooney Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Asthma					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/6, 1987, to 12/1, 1987, that (I) (we) lost saw the deceased alive on 11/6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael A Silva		DEGREE MD		22c. DATE SIGNED 12/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A SILVA		22e. ADDRESS MERCY HOSPITAL 301 ST. PAUL ST. BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 4, 1987	23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland			25a. DATE REC'D. BY REGISTRAR DEC 02 1987		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudolph		

0720 000000

11/2/44

(1)

DEC 03 1944

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

87 REG. NO. 34411

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) CHARLES		FIRST BOWMAN		LAST		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 29, 1987		2b. HOUR 6:05am	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 - 19-1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARTIST		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
13a. STATE MARYLAND		13b. COUNTY --		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1809 FLEET STREET 21231	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY BAUMANN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TIBA ANDRESEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-01-5425		17. INFORMANT ADDRESS RICHARD BOWMAN 3407 ECHODALE AVE. 21214					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CANCER OF COLON, ANEMIA, DEHYDRATION, METABOLIC ACIDOSIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from DECEMBER 28, 1987 to DECEMBER 29, 1987 , that (1) (we) last saw the deceased alive on DECEMBER 29, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. Seceda-Lovio, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Seceda-Lovio, M.D.				22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/02/1988		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeller Inc. 1901 Eastern Ave.				25a. DATE REC'D. BY REGISTRAR DEC 31 1987		25b. REGISTRAR'S SIGNATURE <i>Lila L. Anderson-Lindner</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

23



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34412

1. DECEASED NAME (TYPE OR PRINT) JOHN R. BOWSER				2a. DATE OF DEATH MONTH DAY YEAR 12-13-87		2b. HOUR 9:15P	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6-27-27		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 3600 Franklin St. 21227			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Bowser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Susie Ward			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1945-1953		17. INFORMANT ADDRESS Maxine Bowser 3600 Franklin St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE ANTERIO-LATERAL MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RECURRENT VENTRICULAR ARRHYTHMIAS DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 3600 Franklin St.		21g. CITY OR TOWN Baltimore	
21h. STATE MARYLAND		21i. COUNTY Baltimore		21j. ZIP CODE 21227		21k. DATE SIGNED 12/13/87	
22a. I certify that (1) this hospital attended the deceased from 12/12/87 to 12/13/87 , that (2) (we) last saw this deceased alive on 12/13/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not see the body after death, so state.)							
22b. SIGNATURE CJ Nesbitt MD				22c. DEGREE MD		22d. DATE SIGNED 12/13/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) CJ NESBITT				22f. ADDRESS MERCY HOSPITAL 301 PAUL PLACE BALT, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Brown-Thompson Funeral Home				25a. DATE REG'D. BY REGISTRAR DEC 15 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

0121-1310



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]



076058 DEC 24 1987

Item 18a, b, c, 22a, G639 5-11-88 dw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

4414

FOR
STATE
REGISTRAR
per med exam

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
Gerrod						Boyd		12/ 17/ 87		11:22 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
male	black	9 17 68		19 YRS.				12/ 17/ 19 87		11:22 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md		U S A				Baltimore City,				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Sinai Hospital		Unemployed							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md				Baltimore				3625 Beechler Ave		21215	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Garshell		Boyd		Blanche		Foster					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		214-08-9711		Blanche Boyd		3625 Beechler Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Seizure disorder</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) <u>Chronic Ependymitis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Fungal Infection, NOS</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				12/23/87		Cedar Hill Cemetery				Anne Arundel Co Md	
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. c. March F/H West				4300 Wabash Avenue				DEC 23 1987		Lisa Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MDHMH - 17
(VR A15 ME (5))

100% COTTON EMBROIDERY

WILSON

WILSON



DEC 23 1950

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34413

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALTHEA C. BOYD			2a. DATE OF DEATH MONTH DAY YEAR December 22, 1987		2b. HOUR 9:45 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 7, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	9a. CITIZEN OF WHAT COUNTRY? USA	9b. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
11. CITY OR TOWN OF DEATH Baltimore	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	13b. KIND OF BUSINESS OR INDUSTRY Education	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE MD			14b. COUNTY Balto.	14c. CITY OR TOWN Baltimore	
15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			16. STREET ADDRESS 4401 Roland Ave., 21210		
17. FATHER'S NAME FIRST MIDDLE LAST James G. Boyd		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Atkinson			
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		19b. SOCIAL SECURITY NO. 213 30 8709		19c. INFORMANT Mary B. Grimes, MD	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dementia.</u>					
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
23a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23c. LOCATION STREET CITY OR TOWN COUNTY STATE	
24. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> 19 <u>87</u> , to <u>12/22</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/22</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If withheld, did not view the body after death.)					
25a. SIGNATURE <u>Robert J. Vissing</u>		25b. DEGREE MD		25c. DATE SIGNED 12/23	
26a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert J. Vissing, MD		26b. ADDRESS 4300 N. Charles Street, Balto., MD			
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	27b. DATE 12/26/87	27c. NAME OF CEMETERY OR CREMATORY Druid Ridge		27d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD	
28. FUNERAL DIRECTOR NAME H. W. Jenkins & Sons Co.		29. DATE REC'D. BY REGISTRAR DEC 24 1987			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

100-100000-100000



200-100000-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 REG. NO. 34415			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Selle, A. Boyd				12 18 87 4:14 PM			
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 22 12		6 AGE (IN YEARS LAST BIRTHDAY) YRS 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY NAVY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE JAMES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE ANNIE LEE		13e. STREET ADDRESS / ZIP CODE 416 E. BIDDLE STREET 21202			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 551-36-4147		17 INFORMANT ADDRESS SELENA WALLER 416 E. BIDDLE STREET			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2]			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Keith Fried				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith Fried				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/24/87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS, MD	
24 FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.				25a. DATE REC'D. BY REGISTRAR 25b. ADDRESS 1101 E. NORTH AVENUE			

DEC 23 1987

076668 DEC 31 1987

FOR
STATISTICAL
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

4416

1. DECEASED NAME (TYPE OR PRINT)		FIRST (BILL)		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		21. HOUR					
William		STERLING		Boyd		SR.		12		25		9		87		M					
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		22. HOUR	
MALE		BLACK		5 27 49		38 YRS.		MONTHS		DAYS		HOURS		MIN.		12		25		9 2:27	
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		71. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
VA		USA				Baltimore City															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		Johns Hopkins Hospital		N/A		N/A															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1600 E. BIDDLE STREET													
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST											
UNKNOWN						UNKNOWN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
YES		ARMY		518-66-4035		SHEILA BOYD		1600 E. BIDDLE STREET													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
						DUE TO, OR AS A CONSEQUENCE OF															
						(b)															
						DUE TO, OR AS A CONSEQUENCE OF															
						(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
		HOUR A.M. MONTH DAY YEAR																			
		P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
Mario F. Golle, Jr., M.D.		M.D. Assistant		12/25/87																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		BALTO., MD																	
123a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION															
BURIAL		12/30/87		ARLINGTON		ARLINGTON															
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
WM. C. MARCH F/H		1101 E. NORTH AVENUE				DEC 30 1987		John F. Gordon-Randall													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH : 17
(VR A15 ME (5))

2025 COTTON FIBER

00000

WIKI



00000

076379 DEC 28 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4417

DECEASED NAME (IF OR PRINT)			FIRST Omax			MIDDLE Boykin			LAST			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 24 19 87			2b. HOUR M 9:30 AM		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 13 32		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 55		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 24 19 87			2d. HOUR P 9:30 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LANE CONSTRUCTION CO.				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3443 PARK HEIGHTS 21215									
14. FATHER'S NAME FIRST MIDDLE LAST REV. LEWIS BOYKIN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ALICE HERRING											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 241-44-5443		17. INFORMANT ADDRESS MR. DIXIE BRUNSON 1648 W. NORTH AVE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a <u>Dilated cardiomyopathy</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 12/25/87					
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr. M.D.				ADDRESS 111 Penn St.				Balto. MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/30/87		23c. NAME OF CEMETERY OR CREMATORY FAMILY CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE GARLAND NC							
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE				25a. DATE REC'D. BY REGISTRAR DEC 28 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH PERMITS. 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

57/84
25M

BP

DHMH - 17
(VR A15 ME (5))

20% COTTON FIBER

MADE IN U.S.A.



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 7 REG. NO. 3 4 4 1 8							
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Esther E. Bradfield				2a. DATE OF DEATH MONTH DAY YEAR 12/22/87		2b. HOUR 10:50 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 23 29		6. AGE (IN YEARS LAST BIRTHDAY) 58		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Evergreen Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5528 Hilltop Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Hammond D. Bradfield				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Helen Colvin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 216-74-1349		17. INFORMANT ADDRESS Elizabeth Ohl 5606 Hilltop Ave. 21206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Basal ganglia degeneration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 hours</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Recurrent Infection; Chronic Congestive Heart Failure; Adrenal Insufficiency</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the physician) attended the deceased from <u>Prior to</u> 19 <u>65</u> , to <u>12/22/87</u> , that (I) (we) last saw the deceased alive on <u>12/22/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.									
22b. SIGNATURE <u>Albert D. Bradley</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/22/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert Bradley, M.D.				22e. ADDRESS Evergreen Nursing Home 5837 Belair Rd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-87		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME <u>Cassidy Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE <u>John Benson-Randall</u>	

71301-1-10

71301-1-10

TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

[Illegible handwritten notes and stamps]

077030 JAN 5 88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, death traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR ADALAE D. BRADLEY									
2. DECEASED NAME (1 TYPE OR PRINT) FIRST MIDDLE LAST ADALAE BRADLEY					2a. DATE OF DEATH MONTH DAY YEAR 12/28/87				
3. SEX Female					4. RACE White				
5. DATE OF BIRTH MONTH DAY YEAR 12 31 01					6. AGE (IN YEARS LAST BIRTHDAY) YRS 85				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND					7b. CITIZEN OF WHAT COUNTRY? USA				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTO					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE					12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD					13b. COUNTY BALTO				
13c. CITY OR TOWN BALTO					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS / ZIP CODE 820 S. CATON AVE 21229					14. FATHER'S NAME FIRST MIDDLE LAST GERNHART				
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ---					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				
16b. SOCIAL SECURITY NO. 213094785					17. INFORMANT ADDRESS PAUL BRADLEY 3 DURNESSE CT 21236				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF: (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: (c) ARTEROSCLEROTIC HEART DISEASE									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE 12/18 87 to 12/28 87									
22a. I certify that (I) (this hospital) attended the deceased from 12/28 87, to 12/28 87, that (I) (we) (saw) the deceased alive on 12/28 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.C. Chouvalit, M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED 12/28/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. CHOUVALIT, M.D. 22e. ADDRESS NORTH CHARLES GEN. HOSP.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 12/31/87 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO -- MD									
24. FUNERAL DIRECTOR NAME ADDRESS 1211 Chesaco Ave. 25a. DATE REC'D. BY REGISTRAR DEC 30 1987 25b. REGISTRAR'S SIGNATURE									

BP

055030 1M-208

DEC 30 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		ERVIN R BRADLEY				12-11-87		7:07AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		CAUCASION		08/09/21		66			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		LOCH RAVEN V.A. HOSPITAL		Brick Layer		Construction			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Md				Baltimore				2122 E. BALTIMORE ST 21231	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Ervin R. Bradley		Elsie Engle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes		WWII		213 18 2002		Lealia Easton 712 Pacific Avenue 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC ADENOCARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>11-19</u> , 19 <u>87</u> , to <u>12-11</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12-11</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.									
22a. SIGNATURE		DEGREE		22c. DATE SIGNED					
Jonathan B. Orens, MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12-11-87					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JONATHAN B. ORENS, MD		LOCH RAVEN V.A. HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY			
Burial		12/15/87		Maryland Veterans cem		Garrison Forest Baltimore			
24. FUNERAL DIRECTOR NAME		25a. DATE RECD							
Burgee-Henss Funeral Home 3631 Falls Rd									

BP

075363 121711

MD. 21211 DEC 16 1987
BY REGISTRAR
John Deery, Registrar
BALLO. Co. Md.

074952 DEC 15 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34421

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
CATHERINE GRIFFITH BRADY					DEC	11	87		12:35 M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE	WHITE	MONTH DAY YEAR 4 15 18		69 YRS.	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.			BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (E- NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE	ST. AGNES HOSPITAL		HOUSEWIFE		---				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
MARYLAND			BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	800 UNETTA AVENUE 21229				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST CHARLES MORRIS		FIRST MIDDLE LAST MARY GRIFFITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
NO		217-16-7176		DOUG BRADY 800 UNETTA AVE. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CHRONIC LYMPHOBLASTIC LEUKEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 11</u> 19 <u>87</u> to <u>DEC 11</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>DEC 11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Mundy, M.D.</u>				DEGREE		22c. DATE SIGNED <u>11 Dec '87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>OSCAR MENDEZ, M.D.</u>				22e. ADDRESS <u>ST. AGNES HOSPITAL</u> <u>900 CATON AVE. BALTIMORE, MD 21229</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		12/14/87		LOUDON PARK Maus.		BALTIMORE Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			
				DEC 14 1987					

03/03/2012 12:01

100% C.I. 100% W.C.B.

100% C.I. 100% W.C.B.

100% C.I. 100% W.C.B.

100% C.I. 100% W.C.B.

100% C.I. 100% W.C.B.

076052
6052 DEC 24 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34422

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA MARIE BRAKE			2a. DATE OF DEATH MONTH DAY YEAR 12 21 87		2b. HOUR 4:15A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 3 22		
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2623 Wilkens Avenue		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labeler		12b. KIND OF BUSINESS OR INDUSTRY Distillery		13a. STATE Maryland		
13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 2623 Wilkens Avenue 21223		14. FATHER'S NAME FIRST MIDDLE LAST John Kreiner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Gordon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-18-4195		17. INFORMANT ADDRESS Betty Ann Woolford 702 Jessie Ct. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastases to liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 mo</u> <u>1 yr</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> , 19 <u>87</u> , to <u>12/21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>William C. Waterfield</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>12-22-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Waterfield, William C.		22e. ADDRESS St. Agnes Hosp. Oncology Dept.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR DEC 23 1987		
25b. REGISTRAR'S SIGNATURE <u>John Gordon-Randall</u>						

100-100000

100-100000

075688

DEC 22 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34423

2a. BASED NAME (TYPE OR PRINT) <i>UNKNOWN</i>		FIRST <i>UNKNOWN</i>		MIDDLE <i>UNKNOWN</i>		LAST <i>BRANCH</i>		2b. DATE OF DEATH MONTH DAY YEAR <i>12 19 87</i>		2c. HOUR <i>2:40 PM</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>BLACK</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>07-05-46</i>				6. AGE (IN YEARS LAST BIRTHDAY) <i>41</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto., Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Deaton Medical Center</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>2303 ROUND ROAD 21225</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>HENRY C. BRANCH</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNIE M. TABORN</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-46-4387</i>		17. INFORMANT ADDRESS <i>HENRY BRANCH 3313 HILLSMERE ROAD (21207)</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UNKNOWN</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>SMALL CELL LUNG CANCER</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>UNKNOWN</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <i>12/18</i> , 19 <i>87</i> , to <i>12/19</i> , 19 <i>87</i> , that (we) lost the deceased alive on <i>12/19/87</i> , 19 <i>87</i> , and that in my (our) opinion death occurred on the date and hour and I am the causes stated above; (2) (we) (did not) view the body after death.											
22b. SIGNATURE <i>James C. Richardson MD</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <i>12/19/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES C. RICHARDSON MD</i>						22e. ADDRESS <i>22 S. GREENE ST. BALTO, MD 21201</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12-23-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE, MARYLAND</i>			
24. FUNERAL DIRECTOR NAME <i>Buena Vista Mortuary</i> ADDRESS <i>1913 W. Baltimore</i>						25. DATE RECEIVED BY REGISTRAR <i>DEC 21 1987</i>		25b. REGISTRAR'S SIGNATURE <i>James C. Richardson</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confidentially: Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

075841 C 11023501

100% COTTON FIBER

WILKINSON

074516 DEC

DATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8734424

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NATHANIEL R. BRANCH			2a. DATE OF DEATH MONTH DAY YEAR 12/5/87		2b. HOUR M AM
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 7/20/24		6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 740 Poplar Grove St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter	12b. KIND OF BUSINESS OR INDUSTRY Lumber Co.	
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 740 Poplar Grove St. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel R. Branch, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Woodrum		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO. 214 20 2482		17. INFORMANT Douglass West		ADDRESS 2532 Lauretta Avenue 21223	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Partial Atrial Septal Defect APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/25/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/25/87 to 12/5/87 , that (I) (we) lost saw the deceased alive on 11/25/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED 12/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN OPARA MD		22e. ADDRESS 3300 GARRISON BLVD 30th Ave BALTO. MD 21216			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/9/87	23c. NAME OF CEMETERY OR CREMATORY King Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME James A. Morton & Sons		ADDRESS 1701 Laurens St.		25a. DATE REC'D. BY REGISTRAR DEC - 8 1987	
				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, illegible handwriting on lined paper]

076042 DEC 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34425

1. DECEASED NAME (TYPE OR PRINT) Catherine Brandford			2a. DATE OF DEATH MONTH DAY YEAR 12 17 87			2b. HOUR 7:30 P.M.			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11 20 26		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 23 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N/A		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13e. STREET ADDRESS & ZIP CODE 1736 E Fayette St 21231			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET JOHNSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Galatia Brandford 1736 E. Fayette St. (31)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pre-Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration DUE TO, OR AS A CONSEQUENCE OF (c) multiple strokes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: IDDM, ASCVD, Peripheral Vascular Disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 87 , to 12/17 , 19 87 , that (I) (we) last saw the deceased alive on 12/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alex Torres						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alex Torres						22e. ADDRESS South Balt. Gen. Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/23/87		23c. NAME OF CEMETERY OR CREMATORY Westview Park		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md.		
24. FUNERAL DIRECTOR NAME Estep Bros. F.H. 1300 Eutaw Place						25a. DATE REC'D. BY REGISTRAR DEC 23 1987		25b. REGISTRAR'S SIGNATURE Lisa Anderson-Lindahl	

MEDICAL CERTIFICATION

29

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2

76990 JAN -5 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34426

1. DECEASED NAME (TYPE OR PRINT) Bernice L. Braxton			2a. DATE OF DEATH MONTH DAY YEAR 12 30 87		2b. HOUR 2:17 PM
3. SEX female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 02 17 02		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hospital and Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Fayette & Broadway 21230
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Braxton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-34-9860	17. INFORMANT Peggy Gholston 1022 Benton St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arterio Sclerotic Cardio Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Decubitus Ulcer, faint</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-30</i> , 19 <i>87</i> , to <i>12-30</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>12-30</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Rolando V. Gocom</i> MD				22c. DATE SIGNED 12-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando V. Gocom				22e. ADDRESS 707 E. Fort Ave, Balt. Md 21230	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-5-88	23c. NAME OF CEMETERY OR CREMATORY Mt Zion		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.	
24. FUNERAL DIRECTOR NAME Wm. C. Brown				25a. DATE REC'D. BY REGISTRAR JAN 4 - 1988	
				25b. REGISTRAR'S SIGNATURE <i>John Frederick</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with (72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		DECEASED NAME (PRINT) JOHN ALBERT BRAZIL				2a. DATE OF DEATH MONTH DAY YEAR 12 15 87		2b. HOUR 4:50 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 23 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICE OFFICER		12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY	
13a. STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9015 TAMMY RD., 21236	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT WILLIAM BRAZIL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN C. MURPHY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS JAMES BRAZIL (SON) SAME ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal cell cancer with lung metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12 / 2</u> , 19 <u>87</u> , to <u>12 / 1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12 / 5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S. Aboon Jaoune</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALEM ABOON JAOUNE				22e. ADDRESS Good Samaritan Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/6/87		23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS		23d. LOCATION BALTIMORE COUNTY MD.			
24. NAME OF FUNERAL HOME, INC. SCHUMMUR FUNERAL HOME, INC.				25a. DATE REC'D. BY REGISTRAR DEC - 8 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

7-27-07 10:00 AM

10:00 AM

674369 DEC - 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34428

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT J BRETT, E.D.D.S.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 1, 1987		2b. HOUR 8:32 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 12, 1919		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 68 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DENTIST		12b. KIND OF BUSINESS OR INDUSTRY DENTISTRY	
13a. STATE MARYLAND				13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 4 POMONA WEST, APT. 3 #21208			
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS BRETOVSKY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GUSSIE DANDES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-NAVY		17. INFORMANT ADDRESS MRS. RITA BRETT APT. 8 4 POMONA WEST BALTO., MD 21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>lymphoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>lymphoma</u> (c) <u>lymphoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2.5 yrs</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>32 Nov 87</u> to <u>1 Dec 87</u> , that (I) (we) lost saw the deceased alive on <u>1 Dec 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Peter White Jr</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/1/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PETER WHITE JR</u>		22e. ADDRESS <u>JHH</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				DATE REC'D. BY REGISTRAR DEC - 7 1987		REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

26

RECEIVED
FEB 10 1964
U.S. DEPT. OF JUSTICE

100-350-100

075268 DEC 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 4 4 2 9									
1- FOR STATE REGISTRAR DECEASED NAME FIRST MIDDLE LAST (TYPE OR PRINT) SAMUEL M. BRIM										2a. DATE KNOWN OF ESTI. DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12-10-87		7b. HOUR M 12-10-87							
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan. 20-29 58		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 58		IF UNDER 1 YR. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-10-87		7d. HOUR M 12-15							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ?		12b. KIND OF BUSINESS OR INDUSTRY Steel Co.									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1342 CROFTON RD. 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Brim						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orna McGeigson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) Yes Korean						16b. SOCIAL SECURITY NO. 234-38-1370						17. INFORMANT ADDRESS Chester Cruthfield 2208 Eoff St. 26003 Wheeling W. Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 12-11-87				M.D. MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-16-87		23c. NAME OF CEMETERY OR CREMATORY G.F.V. Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS Md.									
24. FUNERAL DIRECTOR NAME Randolph J. Collick				ADDRESS 2431 E. Oliver St.				25a. DATE REC'D. BY REGISTRAR DEC 13 1987				25b. REGISTRAR'S SIGNATURE							

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

07520 100107

07520 100107

100107 07520

07520 100107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 7 3 4 4 3 0							
1. DECEASED NAME (TYPE OR PRINT) BABY GIRL TWIN A BRISCOE				2a. DATE OF DEATH MONTH DAY YEAR 11/23/87				2b. HOUR 8:25 AM			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 21 87		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 2		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md. 13b. COUNTY BALTO.				13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2118 TUCKER LN 21207			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANET BRISCOE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXTREME IMMATURITY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 11/22/87 , 19____, to 11/23/87 , 19____, that (1) (we) lost saw the deceased alive on 11/23/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stacey A. Hinderlinder M.D.						DEGREE		22c. DATE SIGNED 11/23/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STACEY HINDERLINDER M.D.						22e. ADDRESS FRANCIS SCOTT KEY					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation				23b. DATE 12-1-87		23c. NAME OF CEMETERY OR CREMATORY FSKMC		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md			
24. FUNERAL DIRECTOR NAME FSKMC						24b. ADDRESS 4940 Eastern Ave Balt, Md 21224		25. DATE REC'D BY REGISTRAR DEC 16 1987		25b. REGISTRAR'S SIGNATURE John Anderson-Rodier	

07508 DEC 1967

07508

07508



07508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34431

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST B/G-B BRISCOE		2a. DATE OF DEATH MONTH DAY YEAR 11-21-87		2b. HOUR 4:55 PM	
3. SEX GIRL	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 11-21-87		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY US	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANET BRISCOE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY DISTRESS SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>IMMATURITY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-21-87</u> , 19 <u>87</u> , to <u>11-21</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11-21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FERRIAYA		22e. ADDRESS 4940 EASTERN AV			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-1-87	23c. NAME OF CEMETERY OR CREMATORY FSKMC	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. MD
24. FUNERAL DIRECTOR NAME FSKMC 4940 Eastern Ave Balt. Md 21224		25a. DATE REC'D. BY REGISTRAR DEC 16 1987	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1935 DEC 17 05



Handwritten signature or text at the bottom left.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon portion. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87 REG. NO. 34432				2a DATE OF DEATH MONTH DAY YEAR			
DECEASED NAME (FIRST OR PRINT)		FIRST		MIDDLE		LAST		2b HOUR	
BEVELLY N BRISCOE								12 3 87 4 48 AM	
1 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		BLACK		11 24 34		53 YRS.		MONTHS DAYS HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				City MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto		Bon Secour				Self Employed		Home Improvement	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE	
Md.				Balto				801 Fulton Ave 21217	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
James Lewis Briscoe				Violet Briscoe					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
No				218-28-7814		Radney Briscoe 810 Fremont Ave 21217			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPTICAEEMIA</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PANcytopenia; Severe Liver Disease 2° ch. alcoholism.</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-30-19-87 to 12-3-19-87 that (I) (we) lost saw the deceased alive on 12-2-19-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>DSSALYA</u>				DEGREE				22c. DATE SIGNED 12-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DARSHAN S. SALUJA MD</u>				22e ADDRESS <u>1600 MT Royal Ave, Balto 21217</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
134 B101		12-8-87		Mt Calvary		Balto Md			
24. FUNERAL DIRECTOR NAME <u>James A. Morton & Sons</u>				ADDRESS <u>1701 Laurens</u>		25. DAY REC'D. DATE REGISTRAR <u>DEC 03 1987</u> 25b. REGISTRAR'S SIGNATURE			

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon #2 and #3 and completely filled in by the funeral director. page 3 should be filed within 72 hours after death. page 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 7 3 4 4 3 3 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 2 88 VIOLA T. BRISCOE						2a. DATE OF DEATH MONTH DAY YEAR 12 28 87		2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 05 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2818 Mosher Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY S&M Jewelry Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Samuel Taylor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Rogers		16. STREET ADDRESS / ZIP CODE 2818 Mosher Street, Baltimore, Maryland 21216			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-18-1613		17. INFORMANT ADDRESS Maryland 21216 Raymond L. Ridgeway 2818 Mosher St. Baltimore					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ANEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>CHRONIC RENAL FAILURE (2) HYPOGLYCEMIA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>84</u> , to <u>Dec</u> , 19 <u>1987</u> that (I) (we) lost saw the deceased alive on <u>12/24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. Osei-Wusu MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/31/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. OSEI-WUSU MD</u>				22e. ADDRESS <u>5710 NABASH AVE BALT MD 2115</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/02/1987		23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216						25a. DATE REC'D. BY REGISTRAR JAN 7 1988		25b. REGISTRAR'S SIGNATURE <u>John R. Rader</u>	

THE UNIVERSITY OF CHICAGO
LIBRARY

1911



THE UNIVERSITY OF CHICAGO
LIBRARY

MEDICAL CERTIFICATION

DHMH - 16 50M 1/81
(VRA 15, 4)

12-1-51
BATTION, CASE I
08J TO PT V

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

076571 DEC 30 1987

8 REG. NO. 34435

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARUEL O. BROOKS			2a. DATE OF DEATH MONTH DAY YEAR 12/26/87		2b. HOUR M 1:55 P						
3. SEX M		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 12 3 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty med care				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baltimore Housing		12b. KIND OF BUSINESS OR INDUSTRY BALT. City			
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4400 Springdale Ave 21207		
14. FATHER'S NAME FIRST MIDDLE LAST Oregon A. Brooks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MARTIN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-07-5653		17. INFORMANT ADDRESS Christopher A. Brooks 4400 Springdale Ave						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Advanced Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Neurological Disease DUE TO, OR AS A CONSEQUENCE OF (c) Septic											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/17, 1987, to 12/26, 1987, that (I) (we) last saw the deceased alive on 12/26/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. Arundel MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Arundel MD						22e. ADDRESS 9141 BARTON AVE ECHM 21043					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/30/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H West						ADDRESS 4300 Wabash Ave.		25. DATE REC'D BY REGISTRAR 75. REGISTRAR'S SIGNATURE DEC 29 1987			

BP

010-1 10-30-50

DEC 28 1950

076401 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 3 4 4 3 6

1. DECEASED NAME (TYPE OR PRINT) <u>Julius</u> <u>—</u> <u>Brooks</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12</u> / <u>25</u> / <u>87</u>		2b. HOUR <u>12³⁸</u> AM
3. SEX <u>Male</u>	4. RACE <u>Black</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>03</u> / <u>23</u> / <u>03</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE COUNTRY <u>MD.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>US.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of MD Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>—</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>—</u>
13a. STATE <u>MD</u>			13b. COUNTY <u>Baltimore</u>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <u>1611 Riggs Ave. 21217</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Dennis</u> <u>—</u> <u>Brooks</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>—</u> <u>—</u> <u>—</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>212-09-5932</u>		17. INFORMANT ADDRESS <u>Gayle Harris 1611 Riggs Ave 21217</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> <u>8698</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sepsis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Angina, CVA, Poor Barrel Function S/P Stroke Inhalation</u>					
19a. DATE OF OPERATION <u>12/25</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>—</u> <u>—</u> <u>—</u> <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>—</u> <u>—</u> <u>—</u> <u>—</u>		
22a. I certify that (1) (this hospital) attended the deceased from <u>11/2/87</u> , 19 <u>87</u> , to <u>12/25</u> , 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>12/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death.					
22b. SIGNATURE <u>S. Dellon MD</u>		DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/25/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. Dellon MD</u>			22e. ADDRESS <u>22 S. Greene St. Balt, MD 21201</u>		
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) <u>Burial</u>	23b. DATE <u>12-29-87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eastview</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balt</u> <u>MD</u>		
24. FUNERAL DIRECTOR NAME ADDRESS <u>Jas. A. Morton & Sons 1701 Laurens</u>			25a. DATE REC'D. BY REGISTRAR <u>DEC 28 1987</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

11-01-1971

RECEIVED

DEC 8 1971

076308 DEC 28 1987

Items # 18a- 22a

FOR STATE Film #G636
REGISTRAR 2/23/88, cdl

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

34437
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Carlton MIDDLE Brown LAST		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-25-87 2b. HOUR M 1:23P M	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 8/26/64	6. AGE (IN YEARS) LAST BIRTHDAY 23 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD.		7b. CITIZEN OF WHAT COUNTRY? USA	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinal Hospital	
13a. STATE MD		13b. COUNTY BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST RONALD BROWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLORIA JOHNSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A	
17. INFORMANT ADDRESS ETHEL BAGLEY 4809 OLNEY RD. 21215		18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Methadone intoxication with complications DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Candidians, if any, which gave rise to immediate cause (a) stating the underlying cause last.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/24/1987	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject took drugs		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION CITY OR TOWN STREET COUNTY STATE 2863 Edgewood Circle, North *Balto. City MD	
22a. I certify that I had charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Charles P. Kokes, M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn Street, Baltimore, MD 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/30/87	
23c. NAME OF CEMETERY OR CREMATORY KING MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.	
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HEIGHTS AVE		25a. DATE REC'D. BY REGISTRAR DEC 28 1987	
25b. REGISTRAR'S SIGNATURE John D. ...			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

106505-208070

92812 NOTED 1992

WILLIAM D. DUND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 4 4 3 8

REG. NO.

FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

GREGORY RICH

BROWN

2a. DATE OF DEATH MONTH DAY YEAR 12 26 87 2b. HOUR 2305 M

3. SEX

male

4. RACE

black

5. DATE OF BIRTH

MONTH DAY YEAR 10 6 87

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN

YRS. 2

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

ST AGNES Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

INPATIENT

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

628 PITCHER STREET 21217

14. FATHER'S NAME

FIRST GREGORY

MIDDLE

LAST RICH

15. MOTHER'S MAIDEN NAME

FIRST MABLE

MIDDLE

LAST BROWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

N/A

17. INFORMANT

Gloria R. RICHMOND

ADDRESS ST AGNES Hospital

700 CARM AVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) COR Pulmonale, PNEUMOPNEUMOTHORAX

DUE TO, OR AS A CONSEQUENCE OF

(c) SEVERE BRONCHOPULMONARY DYSPLASIA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):

GIV IVN

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 6/87, 19 87, to DEC 27 19 87, that (I) (we) lost saw the deceased alive on DEC 26 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Gloria R. RICHMOND

DEGREE

MD

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

12-27-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Gloria R. RICHMOND MD

22e. ADDRESS

ST AGNES Hospital 900 CARM AVE Baltimore MD 21229

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

12/30/87

23c. NAME OF CEMETERY OR CREMATORY

CEDAR HILL CEM.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

ANNE ARUNDEL CO.

MD

24. FUNERAL DIRECTOR

NAME

ADDRESS

WM. C. MARCH F/H 1101 E. NORTH AVENUE

25. DATE REC'D. BY REGISTRAR

DEC 30 1987

25b. REGISTRAR'S SIGNATURE

80% COTTON FIBER

WHEATON 1000

DEC 30 1952

UNKNOWN #87-133

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 4 4 3 9

FOR
STATE
REGISTRAR

075730 DEC 22 1987

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
JAMES		L.		BROWN		2c. DATE OF DEATH				2d. HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7. IF UNDER 24 HRS.		8. DATE PRONOUNCED DEAD		9. BALTIMORE CITY OR COUNTY OF DEATH	
M		B		2 18 48 39 YRS.		39 YRS.		MONTHS		DAYS		12 12 19 87		8:08 AM	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED		12. NEVER MARRIED		12. WIDOWED		12. DIVORCED		13. BALTIMORE CITY		13. BALTIMORE CITY	
MD.		U.S.A.		13. MARRIED		13. NEVER MARRIED		13. WIDOWED		13. DIVORCED		Baltimore City		MD	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY		18. CITY OR TOWN OF DEATH		18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		20. KIND OF BUSINESS OR INDUSTRY	
Baltimore		street - 340 W. North Ave.		21. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		22. KIND OF BUSINESS OR INDUSTRY		23. CITY OR TOWN OF DEATH		23. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		24. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		25. KIND OF BUSINESS OR INDUSTRY	
26. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		27. CITY OR TOWN		28. INSIDE CITY LIMITS?		29. STREET ADDRESS		30. CITY OR TOWN OF DEATH		30. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		31. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		32. KIND OF BUSINESS OR INDUSTRY	
MD.		BALTIMORE		YES X NO		401 CENTRAL AVE.		2/209		33. CITY OR TOWN OF DEATH		33. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		34. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
35. FATHER'S NAME		36. MOTHER'S MAIDEN NAME		37. SOCIAL SECURITY NO.		38. INFORMANT		39. ADDRESS		40. CITY OR TOWN OF DEATH		40. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		41. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. CITY OR TOWN OF DEATH		19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		21. KIND OF BUSINESS OR INDUSTRY	
(YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. ADDRESS		19. CITY OR TOWN OF DEATH		19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		21. KIND OF BUSINESS OR INDUSTRY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Congestive heart failure															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION															
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY?															
YES X NO															
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH															
21b. TIME OF INJURY															
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED															
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)															
21f. LOCATION															
21g. CITY OR TOWN															
21h. COUNTY															
21i. STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner.															
22b. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner.															
23. ACTUAL SIGNATURE															
24. EXAMINER'S NAME (TYPE OR PRINT)															
25. ADDRESS															
26. DATE REC'D. BY REGISTRAR															
27. REGISTRAR'S SIGNATURE															
28. DATE REC'D. BY REGISTRAR															
29. REGISTRAR'S SIGNATURE															

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1A, 1B, 1C, 1D, 1E, 1F, 1G, 1H, 1I, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1R, 1S, 1T, 1U, 1V, 1W, 1X, 1Y, 1Z, 2A, 2B, 2C, 2D, 2E, 2F, 2G, 2H, 2I, 2J, 2K, 2L, 2M, 2N, 2O, 2P, 2Q, 2R, 2S, 2T, 2U, 2V, 2W, 2X, 2Y, 2Z, 3A, 3B, 3C, 3D, 3E, 3F, 3G, 3H, 3I, 3J, 3K, 3L, 3M, 3N, 3O, 3P, 3Q, 3R, 3S, 3T, 3U, 3V, 3W, 3X, 3Y, 3Z, 4A, 4B, 4C, 4D, 4E, 4F, 4G, 4H, 4I, 4J, 4K, 4L, 4M, 4N, 4O, 4P, 4Q, 4R, 4S, 4T, 4U, 4V, 4W, 4X, 4Y, 4Z, 5A, 5B, 5C, 5D, 5E, 5F, 5G, 5H, 5I, 5J, 5K, 5L, 5M, 5N, 5O, 5P, 5Q, 5R, 5S, 5T, 5U, 5V, 5W, 5X, 5Y, 5Z, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 6I, 6J, 6K, 6L, 6M, 6N, 6O, 6P, 6Q, 6R, 6S, 6T, 6U, 6V, 6W, 6X, 6Y, 6Z, 7A, 7B, 7C, 7D, 7E, 7F, 7G, 7H, 7I, 7J, 7K, 7L, 7M, 7N, 7O, 7P, 7Q, 7R, 7S, 7T, 7U, 7V, 7W, 7X, 7Y, 7Z, 8A, 8B, 8C, 8D, 8E, 8F, 8G, 8H, 8I, 8J, 8K, 8L, 8M, 8N, 8O, 8P, 8Q, 8R, 8S, 8T, 8U, 8V, 8W, 8X, 8Y, 8Z, 9A, 9B, 9C, 9D, 9E, 9F, 9G, 9H, 9I, 9J, 9K, 9L, 9M, 9N, 9O, 9P, 9Q, 9R, 9S, 9T, 9U, 9V, 9W, 9X, 9Y, 9Z, 10A, 10B, 10C, 10D, 10E, 10F, 10G, 10H, 10I, 10J, 10K, 10L, 10M, 10N, 10O, 10P, 10Q, 10R, 10S, 10T, 10U, 10V, 10W, 10X, 10Y, 10Z, 11A, 11B, 11C, 11D, 11E, 11F, 11G, 11H, 11I, 11J, 11K, 11L, 11M, 11N, 11O, 11P, 11Q, 11R, 11S, 11T, 11U, 11V, 11W, 11X, 11Y, 11Z, 12A, 12B, 12C, 12D, 12E, 12F, 12G, 12H, 12I, 12J, 12K, 12L, 12M, 12N, 12O, 12P, 12Q, 12R, 12S, 12T, 12U, 12V, 12W, 12X, 12Y, 12Z, 13A, 13B, 13C, 13D, 13E, 13F, 13G, 13H, 13I, 13J, 13K, 13L, 13M, 13N, 13O, 13P, 13Q, 13R, 13S, 13T, 13U, 13V, 13W, 13X, 13Y, 13Z, 14A, 14B, 14C, 14D, 14E, 14F, 14G, 14H, 14I, 14J, 14K, 14L, 14M, 14N, 14O, 14P, 14Q, 14R, 14S, 14T, 14U, 14V, 14W, 14X, 14Y, 14Z, 15A, 15B, 15C, 15D, 15E, 15F, 15G, 15H, 15I, 15J, 15K, 15L, 15M, 15N, 15O, 15P, 15Q, 15R, 15S, 15T, 15U, 15V, 15W, 15X, 15Y, 15Z, 16A, 16B, 16C, 16D, 16E, 16F, 16G, 16H, 16I, 16J, 16K, 16L, 16M, 16N, 16O, 16P, 16Q, 16R, 16S, 16T, 16U, 16V, 16W, 16X, 16Y, 16Z, 17A, 17B, 17C, 17D, 17E, 17F, 17G, 17H, 17I, 17J, 17K, 17L, 17M, 17N, 17O, 17P, 17Q, 17R, 17S, 17T, 17U, 17V, 17W, 17X, 17Y, 17Z, 18A, 18B, 18C, 18D, 18E, 18F, 18G, 18H, 18I, 18J, 18K, 18L, 18M, 18N, 18O, 18P, 18Q, 18R, 18S, 18T, 18U, 18V, 18W, 18X, 18Y, 18Z, 19A, 19B, 19C, 19D, 19E, 19F, 19G, 19H, 19I, 19J, 19K, 19L, 19M, 19N, 19O, 19P, 19Q, 19R, 19S, 19T, 19U, 19V, 19W, 19X, 19Y, 19Z, 20A, 20B, 20C, 20D, 20E, 20F, 20G, 20H, 20I, 20J, 20K, 20L, 20M, 20N, 20O, 20P, 20Q, 20R, 20S, 20T, 20U, 20V, 20W, 20X, 20Y, 20Z, 21A, 21B, 21C, 21D, 21E, 21F, 21G, 21H, 21I, 21J, 21K, 21L, 21M, 21N, 21O, 21P, 21Q, 21R, 21S, 21T, 21U, 21V, 21W, 21X, 21Y, 21Z, 22A, 22B, 22C, 22D, 22E, 22F, 22G, 22H, 22I, 22J, 22K, 22L, 22M, 22N, 22O, 22P, 22Q, 22R, 22S, 22T, 22U, 22V, 22W, 22X, 22Y, 22Z, 23A, 23B, 23C, 23D, 23E, 23F, 23G, 23H, 23I, 23J, 23K, 23L, 23M, 23N, 23O, 23P, 23Q, 23R, 23S, 23T, 23U, 23V, 23W, 23X, 23Y, 23Z, 24A, 24B, 24C, 24D, 24E, 24F, 24G, 24H, 24I, 24J, 24K, 24L, 24M, 24N, 24O, 24P, 24Q, 24R, 24S, 24T, 24U, 24V, 24W, 24X, 24Y, 24Z, 25A, 25B, 25C, 25D, 25E, 25F, 25G, 25H, 25I, 25J, 25K, 25L, 25M, 25N, 25O, 25P, 25Q, 25R, 25S, 25T, 25U, 25V, 25W, 25X, 25Y, 25Z, 26A, 26B, 26C, 26D, 26E, 26F, 26G, 26H, 26I, 26J, 26K, 26L, 26M, 26N, 26O, 26P, 26Q, 26R, 26S, 26T, 26U, 26V, 26W, 26X, 26Y, 26Z, 27A, 27B, 27C, 27D, 27E, 27F, 27G, 27H, 27I, 27J, 27K, 27L, 27M, 27N, 27O, 27P, 27Q, 27R, 27S, 27T, 27U, 27V, 27W, 27X, 27Y, 27Z, 28A, 28B, 28C, 28D, 28E, 28F, 28G, 28H, 28I, 28J, 28K, 28L, 28M, 28N, 28O, 28P, 28Q, 28R, 28S, 28T, 28U, 28V, 28W, 28X, 28Y, 28Z, 29A, 29B, 29C, 29D, 29E, 29F, 29G, 29H, 29I, 29J, 29K, 29L, 29M, 29N, 29O, 29P, 29Q, 29R, 29S, 29T, 29U, 29V, 29W, 29X, 29Y, 29Z, 30A, 30B, 30C, 30D, 30E, 30F, 30G, 30H, 30I, 30J, 30K, 30L, 30M, 30N, 30O, 30P, 30Q, 30R, 30S, 30T, 30U, 30V, 30W, 30X, 30Y, 30Z, 31A, 31B, 31C, 31D, 31E, 31F, 31G, 31H, 31I, 31J, 31K, 31L, 31M, 31N, 31O, 31P, 31Q, 31R, 31S, 31T, 31U, 31V, 31W, 31X, 31Y, 31Z, 32A, 32B, 32C, 32D, 32E, 32F, 32G, 32H, 32I, 32J, 32K, 32L, 32M, 32N, 32O, 32P, 32Q, 32R, 32S, 32T, 32U, 32V, 32W, 32X, 32Y, 32Z, 33A, 33B, 33C, 33D, 33E, 33F, 33G, 33H, 33I, 33J, 33K, 33L, 33M, 33N, 33O, 33P, 33Q, 33R, 33S, 33T, 33U, 33V, 33W, 33X, 33Y, 33Z, 34A, 34B, 34C, 34D, 34E, 34F, 34G, 34H, 34I, 34J, 34K, 34L, 34M, 34N, 34O, 34P, 34Q, 34R, 34S, 34T, 34U, 34V, 34W, 34X, 34Y, 34Z, 35A, 35B, 35C, 35D, 35E, 35F, 35G, 35H, 35I, 35J, 35K, 35L, 35M, 35N, 35O, 35P, 35Q, 35R, 35S, 35T, 35U, 35V, 35W, 35X, 35Y, 35Z, 36A, 36B, 36C, 36D, 36E, 36F, 36G, 36H, 36I, 36J, 36K, 36L, 36M, 36N, 36O, 36P, 36Q, 36R, 36S, 36T, 36U, 36V, 36W, 36X, 36Y, 36Z, 37A, 37B, 37C, 37D, 37E, 37F, 37G, 37H, 37I, 37J, 37K, 37L, 37M, 37N, 37O, 37P, 37Q, 37R, 37S, 37T, 37U, 37V, 37W, 37X, 37Y, 37Z, 38A, 38B, 38C, 38D, 38E, 38F, 38G, 38H, 38I, 38J, 38K, 38L, 38M, 38N, 38O, 38P, 38Q, 38R, 38S, 38T, 38U, 38V, 38W, 38X, 38Y, 38Z, 39A, 39B, 39C, 39D, 39E, 39F, 39G, 39H, 39I, 39J, 39K, 39L, 39M, 39N, 39O, 39P, 39Q, 39R, 39S, 39T, 39U, 39V, 39W, 39X, 39Y, 39Z, 40A, 40B, 40C, 40D, 40E, 40F, 40G, 40H, 40I, 40J, 40K, 40L, 40M, 40N, 40O, 40P, 40Q, 40R, 40S, 40T, 40U, 40V, 40W, 40X, 40Y, 40Z, 41A, 41B, 41C, 41D, 41E, 41F, 41G, 41H, 41I, 41J, 41K, 41L, 41M, 41N, 41O, 41P, 41Q, 41R, 41S, 41T, 41U, 41V, 41W, 41X, 41Y, 41Z, 42A, 42B, 42C, 42D, 42E, 42F, 42G, 42H, 42I, 42J, 42K, 42L, 42M, 42N, 42O, 42P, 42Q, 42R, 42S, 42T, 42U, 42V, 42W, 42X, 42Y, 42Z, 43A, 43B, 43C, 43D, 43E, 43F, 43G, 43H, 43I, 43J, 43K, 43L, 43M, 43N, 43O, 43P, 43Q, 43R, 43S, 43T, 43U, 43V, 43W, 43X, 43Y, 43Z, 44A, 44B, 44C, 44D, 44E, 44F, 44G, 44H, 44I, 44J, 44K, 44L, 44M, 44N, 44O, 44P, 44Q, 44R, 44S, 44T, 44U, 44V, 44W, 44X, 44Y, 44Z, 45A, 45B, 45C, 45D, 45E, 45F, 45G, 45H, 45I, 45J, 45K, 45L, 45M, 45N, 45O, 45P, 45Q, 45R, 45S, 45T, 45U, 45V, 45W, 45X, 45Y, 45Z, 46A, 46B, 46C, 46D, 46E, 46F, 46G, 46H, 46I, 46J, 46K, 46L, 46M, 46N, 46O, 46P, 46Q, 46R, 46S, 46T, 46U, 46V, 46W, 46X, 46Y, 46Z, 47A, 47B, 47C, 47D, 47E, 47F, 47G, 47H, 47I, 47J, 47K, 47L, 47M, 47N, 47O, 47P, 47Q, 47R, 47S, 47T, 47U, 47V, 47W, 47X, 47Y, 47Z, 48A, 48B, 48C, 48D, 48E, 48F, 48G, 48H, 48I, 48J, 48K, 48L, 48M, 48N, 48O, 48P, 48Q, 48R, 48S, 48T, 48U, 48V, 48W, 48X, 48Y, 48Z, 49A, 49B, 49C, 49D, 49E, 49F, 49G, 49H, 49I, 49J, 49K, 49L, 49M, 49N, 49O, 49P, 49Q, 49R, 49S, 49T, 49U, 49V, 49W, 49X, 49Y, 49Z, 50A, 50B, 50C, 50D, 50E, 50F, 50G, 50H, 50I, 50J, 50K, 50L, 50M, 50N, 50O, 50P, 50Q, 50R, 50S, 50T, 50U, 50V, 50W, 50X, 50Y, 50Z, 51A, 51B, 51C, 51D, 51E, 51F, 51G, 51H, 51I, 51J, 51K, 51L, 51M, 51N, 51O, 51P, 51Q, 51R, 51S, 51T, 51U, 51V, 51W, 51X, 51Y, 51Z, 52A, 52B, 52C, 52D, 52E, 52F, 52G, 52H, 52I, 52J, 52K, 52L, 52M, 52N, 52O, 52P, 52Q, 52R, 52S, 52T, 52U, 52V, 52W, 52X, 52Y, 52Z, 53A, 53B, 53C, 53D, 53E, 53F, 53G, 53H, 53I, 53J, 53K, 53L, 53M, 53N, 53O, 53P, 53Q, 53R, 53S, 53T, 53U, 53V, 53W, 53X, 53Y, 53Z, 54A, 54B, 54C, 54D, 54E, 54F, 54G, 54H, 54I, 54J, 54K, 54L, 54M, 54N, 54O, 54P, 54Q, 54R, 54S, 54T, 54U, 54V, 54W, 54X, 54Y, 54Z, 55A, 55B, 55C, 55D, 55E, 55F, 55G, 55H, 55I, 55J, 55K, 55L, 55M, 55N, 55O, 55P, 55Q, 55R, 55S, 55T, 55U, 55V, 55W, 55X, 55Y, 55Z, 56A, 56B, 56C, 56D, 56E, 56F, 56G, 56H, 56I, 56J, 56K, 56L, 56M, 56N, 56O, 56P, 56Q, 56R, 56S, 56T, 56U, 56V, 56W, 56X, 56Y, 56Z, 57A, 57B, 57C, 57D, 57E, 57F, 57G, 57H, 57I, 57J, 57K, 57L, 57M, 57N, 57O, 57P, 57Q, 57R, 57S, 57T, 57U, 57V, 57W, 57X, 57Y, 57Z, 58A, 58B, 58C, 58D, 58E, 58F, 58G, 58H, 58I, 58J, 58K, 58L, 58M, 58N, 58O, 58P, 58Q, 58R, 58S, 58T, 58U, 58V, 58W, 58X, 58Y, 58Z, 59A, 59B, 59C, 59D, 59E, 59F, 59G, 59H, 59I, 59J, 59K, 59L, 59M, 59N, 59O, 59P, 59Q, 59R, 59S, 59T, 59U, 59V, 59W, 59X, 59Y, 59Z, 60A, 60B, 60C, 60D, 60E, 60F, 60G, 60H, 60I, 60J, 60K, 60L, 60M, 60N, 60O, 60P, 60Q, 60R, 60S, 60T, 60U, 60V, 60W, 60X, 60Y, 60Z, 61A, 61B, 61C, 61D, 61E, 61F, 61G, 61H, 61I, 61J, 61K, 61L, 61M, 61N, 61O, 61P, 61Q, 61R, 61S, 61T, 61U, 61V, 61W, 61X, 61Y, 61Z, 62A, 62B, 62C, 62D, 62E, 62F, 62G, 62H, 62I, 62J, 62K, 62L, 62M, 62N, 62O, 62P, 62Q, 62R, 62S, 62T, 62U, 62V, 62W, 62X, 62Y, 62Z, 63A, 63B, 63C, 63D, 63E, 63F, 63G, 63H, 63I, 63J, 63K, 63L, 63M, 63N, 63O, 63P, 63Q, 63R, 63S, 63T, 63U, 63V, 63W, 63X, 63Y, 63Z, 64A, 64B, 64C, 64D, 64E, 64F, 64G, 64H, 64I, 64J, 64K, 64L, 64M, 64N, 64O, 64P, 64Q, 64R, 64S, 64T, 64U, 64V, 64W, 64X, 64Y, 64Z, 65A, 65B, 65C, 65D, 65E, 65F, 65G, 65H, 65I, 65J, 65K, 65L, 65M, 65N, 65O, 65P, 65Q, 65R, 65S, 65T, 65U, 65V, 65W, 65X, 65Y, 65Z, 66A, 66B, 66C, 66D, 66E, 66F, 66G, 66H, 66I, 66J, 66K, 66L, 66M, 66N, 66O, 66P, 66Q, 66R, 66S, 66T, 66U, 66V, 66W, 66X, 66Y, 66Z, 67A, 67B, 67C, 67D, 67E, 67F, 67G, 67H, 67I, 67J, 67K, 67L, 67M, 67N, 67O, 67P, 67Q, 67R, 67S, 67T, 67U, 67V, 67W, 67X, 67Y, 67Z, 68A, 68B, 68C, 68D, 68E, 68F, 68G, 68H, 68I, 68J, 68K, 68L, 68M, 68N, 68O, 68P, 68Q, 68R, 68S, 68T, 68U, 68V, 68W, 68X, 68Y, 68Z, 69A, 69B, 69C, 69D, 69E, 69F, 69G, 69H, 69I, 69J, 69K, 69L, 69M, 69N, 69O, 69P, 69Q, 69R, 69S, 69T, 69U, 69V, 69W, 69X, 69Y, 69Z, 70A, 70B, 70C, 70D, 70E, 70F, 70G, 70H, 70I, 70J, 70K, 70L, 70M, 70N, 70O, 70P, 70Q, 70R, 70S, 70T, 70U, 70V, 70W, 70X, 70Y, 70Z, 71A, 71B, 71C, 71D, 71E, 71F, 71G, 71H, 71I, 71J, 71K, 71L, 71M, 71N, 71O, 71P, 71Q, 71R, 71S, 71T, 71U, 71V, 71W, 71X, 71Y, 71Z, 72A, 72B, 72C, 72D, 72E, 72F, 72G, 72H, 72I, 72J, 72K, 72L, 72M, 72N, 72O, 72P, 72Q, 72R, 72S, 72T, 72U, 72V, 72W, 72X, 72Y, 72Z, 73A, 73B, 73C, 73

103300 101050

DAVID
MAYFIELD



[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34440

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jean Brown			2a. DATE OF DEATH MONTH DAY YEAR 12 16 87			2b. HOUR 10:00 P.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 8 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montpelier, Idaho		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 312 Tuscaney Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 312 Tuscaney rd. 21210	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Severn			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -----			16b. SOCIAL SECURITY NO. 011-6948D	
17. INFORMANT Mrs. Elizabeth Murphy, Box 269 Upper Falls, Md.			17. ADDRESS 21156			17. ADDRESS 21156			17. ADDRESS 21156	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thymoma of chest</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 3 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 16</u> 19 <u>87</u> to <u>Dec 16</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Dec 16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (If we (I) did not view the body after death.										
22b. SIGNATURE <u>ST. B. Bell</u>			22c. DATE SIGNED <u>12/17/87</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STUART B. BELL MD</u>				
22e. ADDRESS <u>3501 ST. Paul st</u>			22f. ADDRESS <u>3501 ST. Paul st</u>			22g. ADDRESS <u>3501 ST. Paul st</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-21-1987			23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.	
24. FUNERAL DIRECTOR NAME E.F. Lassahn F.H. 11750 Belair Rd. Kingsville, Md.						25a. DATE REC'D. BY REGISTRAR 12-21-1987		25b. REGISTRAR'S SIGNATURE <u>Davidson-Rodgers</u>		

NOV 10 1964

01



SECTION
LIBRARY

OTC
F. B. I.

075526

DEC 2 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34441

1. DECEASED NAME (TYPE OR PRINT) LORETTA H. BROWN			2a. DATE OF DEATH MONTH DAY YEAR 12-12-87			2b. HOUR 907 P.M.			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 01 08 02		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY PVT. FAMILIES	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION) GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BAPTIST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANNIE DESHIELDS				16. ADDRESS EASTON, MD. 21601	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO.				16b. 218-64-2158		17. INFORMANT HERBERT J. DESHIELDS P.O. BOX 186			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF, (b) Cardiac Possible & Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF, (c) Infection & Renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from 12/12 , 19 87 , to 12/12 , 19 87 , that <input checked="" type="checkbox"/> I saw the deceased alive on 12/12 , 19 87 , and that in my opinion death occurred on the date and hour and from the causes stated above. (If the doctor did not view the body after death, check this box.)							
22b. SIGNATURE J. Griffin				DEGREE MD		22c. DATE SIGNED 12/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Griffin				22e. ADDRESS 2600 Liberty Height			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/17/1987		23c. NAME OF CEMETERY OR CREMATORY ST. STEPHENS CEM. AME CH.		23d. LOCATION CITY OR TOWN COUNTY STATE TALBOT, MD.	
24. FUNERAL HOME NAME ADDRESS NEWER FUNERAL HOMES, INC., 2501 GWYNNS FALLS PKWY. BALTO, MD. 21216				25a. DATE REC'D. BY REGISTRAR DEC 18 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry to hear that you are not satisfied with the results of the examination of the specimens of the water from the well at the site of the proposed water works.

I have caused the specimens to be re-examined by a competent chemist, and the results of the examination are as follows:

The water is found to be of good quality, and is free from any impurities which would render it unfit for domestic use.

I am, Sir, very respectfully,
Your obedient servant,
J. W. Waterbury

075181 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34442

1. DECEASED NAME (TYPE OR PRINT) Mary E Brown			2a. DATE OF DEATH MONTH 12 DAY 2 YEAR 87		2b. HOUR 12:40 P
3. SEX F	4. RACE white	5. DATE OF BIRTH MONTH 1 DAY 19 YEAR 19		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY OF BALTIMORE MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Ind.			13b. COUNTY Balti.	13c. CITY OR TOWN Balti.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Domènich MIDDLE Paparo LAST Paparo		15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Vick LAST Vick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-0999		16c. INFORMANT ADDRESS 21290 Albert A. Brown 1229 Carroll St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC 2 19 87 , to DEC 2 19 87 , that (I) (we) last saw the deceased alive on DEC 2 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Ulibers		DEGREE		22c. DATE SIGNED 12/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) URIBE		22e. ADDRESS 22 S. Greene Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-1987		23c. NAME OF CEMETERY OR CREMATOR St. Olmest Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balti. Ind.		23e. NAME OF FUNERAL HOME Buch. Ind. 21223		23f. ADDRESS 901 Hillens St.	
24. FUNERAL DIRECTOR NAME John E. Brown		25a. DATE REC'D. BY REGISTRAR DEC 09 1987		25b. REGISTRAR'S SIGNATURE John E. Brown	

BP

16/2/50

8

16/2/50

16/2/50

16/2/50

075840 DEC 22 1987

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 4443

FOR
1- STATE
2- REGISTRAR1- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Melvin

W.

Brown, Sr.

2a. DATE KNOWN OF ESTI-
DEATH MATED ☒ MONTH ☐ DAY ☐ YEAR ☐ HOUR

3. SEX

4. RACE

5. DATE OF BIRTH
MONTH DAY YEAR6. AGE (IN YEARS
LAST BIRTHDAY)

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

7c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR

2d. HOUR
11:34 a7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS
OR INDUSTRY

Baltimore

St. Agnes Hospital

Painter

Construction

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?
YES ☐ NO ☒13e. STREET ADDRESS
1703 Rittenhouse Ave 2122714. FATHER'S NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST14. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH REG. NO. 4. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT: PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE
SIGNED 12/20/87EXAMINER'S NAME
(TYPE OR PRINT)

Mario F. Golle, Jr, M.D.

ADDRESS

111 Penn St.

Balto, MD.

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

12/23/87

23c. NAME OF CEMETERY OR CREMATORY

Maryland Veterans

23d. LOCATION
CITY OR TOWN COUNTY STATE

Crownsville Anne Arundel Md

24. FUNERAL DIRECTOR
NAME

ADDRESS

Ambrose Funeral Home 1328 Sulphur Spring Rd.

25a. DATE REC'D. BY REGISTRAR

DEC 21 1987

25b. REGISTRAR'S SIGNATURE

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

20% COTTON FIBER

HIEFMAN



10-20-30 0-100-20

074954 DEC 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC 3 4 4 4 4

FOR
1- STATE
REGISTRAR

2- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

NATHAN

BROWN

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

12 2 45

6. AGE (IN YEARS)

42

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. DATE KNOWN
OF ESTI-
DEATH MATEDMONTH DAY YEAR
12 11 19877b. HOUR
M7c. DATE
PRONOUNCED
DEADMONTH DAY YEAR
12 11 19877d. HOUR
M7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Sinai Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Prison guard

12b. KIND OF BUSINESS
OR INDUSTRY

State of MD

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4703 Parkside Gardenway Apt. 6

14. FATHER'S NAME

Nathan

MIDDLE

Edmondson

LAST

15. MOTHER'S MAIDEN NAME

Josephine

MIDDLE

Cheeks

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

yes

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

Vietnam

16c. SOCIAL SECURITY NO.

205 34 6054

17. INFORMANT

Josephine Brown 466 Second St.

ADDRESS Duquesne, Pa.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Perforating gunshot wound of head

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

Head only
YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR MIN. MONTH DAY YEAR
11:25 M. 12-11- 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Self-inflicted

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

auto

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE
4600 blk. York Rd., Balto. MD

22a. I certify that I took charge of the remains described above, held an

Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURETITLE (SPECIFY)
M.D. Deputy Chief

MEDICALEXAMINER

DATE SIGNED 12-12-87

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

burial

23b. DATE

12-17-87

23c. NAME OF CEMETERY OR CREMATORY

McKeesport & Vegallie

23d. LOCATION

CITY OR TOWN COUNTY STATE
McKeesport, Pa.24. FUNERAL DIRECTOR
NAME

Gary L. Kaufman 5695 Main St., Elkridge, Md. 21227

25a. DATE REC'D. BY REGISTRAR

DEC 14 1987

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-B4
25MA

BP

DHMH - 17
(VR A15 ME (5))

076001 REC 12/81

Male Black 12 2 42

x

Pennsylvania U.S.A.

State of PA Prison Guard

Maryland Baltimore X 4703 Parkside Gardens, Apt. 3

Nathan Josephine Josephine

Yes Vietnam 205 34 0054 Josephine Brown 102 Second St. Inverness, Pa. Checks

Unlaid 12-17-87 Keesport & Verapille Keesport, Pa.

Gary L. Kautman 205 Main St., Ellikage, Pa. 21227

075496 DEC 18 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 3 4 4 4 5

1. DECEASED NAME (TYPE OR PRINT) Roger Miller Brown			2a. DATE OF DEATH MONTH DAY YEAR 1 12 10 87		2b. HOUR 17:20 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 17 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Trucking Co.
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roger B. Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Miller			
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT 212 S. Athol Avenue-Balto., Md. Mrs. Anna M. Brown #21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septic shock DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/19 1987, to 12/10 1987, that (I) (we) lost the deceased alive on 12/10 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE WALID KHAYR, M.D.		DEGREE		22c. DATE SIGNED 12/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALID KHAYR, M.D.		22e. ADDRESS St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1987	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR NAME G. Thuman Schwab		25a. DATE REC'D. BY REGISTRAR DEC 17 1987		25b. REGISTRAR'S SIGNATURE Julia Garrison-Randall	

BP

DHMH - 16 50M 1/81
(VRA 15, 4)



075872 DEC 22 1987

Item 18 1&2, 20, 22a G635 1-11-88

FOR
1- STATE dw per med exam
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 4446

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
Vanessa						Brown		12-13 19 87		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	
FEMALE	BLACK	9- 16- 55		32 YRS.						12-13 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				2d. HOUR	
MARYLAND		US				Baltimore City,				1:32 P. M.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore City		Liberty Medical Center				UNEMPLOYEED					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3102 WINDSOR AVE, 21216	
14. FATHER'S NAME FIRST				MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	
BERNARD						BROWN		HESTER		BROWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				220-64-7771		CHART					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure Disorder</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
Hemoglobinopathy											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Mario F. Golle, Jr.</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-14-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Mario F. Golle, Jr., M.D.				111 Penn St., Balto., Md.				21201			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY	
BURIAL				12-18-87		CEDAR HILL CEMT.		BALTIMORE		MARYLAND	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
E.L. PHILLIPS 1721 N. MONROE STREET						DEC 21 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCILING HEREIN. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10A, 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT, PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25MDHMM : 17
(VR AT5 ME (5))

20% COTTON FIBER

WIND


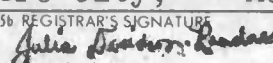
WIKI

WIKI



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)		FIRST VERNON		MIDDLE D.		LAST BROWN Jr.		2a. DATE KNOWN OF DEATH DATE MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 16 87				2b. HOUR M 12:12					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 12 54		6. AGE (IN YEARS) (LAST BIRTHDAY) 33 YRS		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 16 87		7d. HOUR A M 12:12					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Engr.				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 828 Bridgeview Rd. 21228									
14. FATHER'S NAME Donald D. Brown Sr.				15. MOTHER'S MAIDEN NAME Mollie Goods				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 222-58-1324		17. INFORMANT Mrs. Harriett R. Brown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotic intoxication complicated by drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/16 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject using drugs in bathtub & became submerged.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1206 Slater Ct., Balto., Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 12-16-87					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/21/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.							
24. FUNERAL DIRECTOR NAME ADDRESS Chatman-Harris FH 1701 McCulloh Street						25a. DATE REC'D. BY REGISTRAR DEC 22 1987				25b. REGISTRAR'S SIGNATURE 							

050000000000

20% COTTON FIBER

WIND

WIND



[Handwritten signature]

1950

26

1912

X

1912



1912

1912

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 3 4 4 4 9

1. DECEASED NAME (TYPE OR PRINT) WILLIAM		MIDDLE Carroll		LAST BRYAN		2a. DATE OF DEATH MONTH 12 DAY 5 YEAR 87		2b. HOUR 6:32 PM	
3. SEX M		4. RACE C		5. DATE OF BIRTH MONTH 6 DAY 13 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U,S,A,		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Western Electric	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 432 Elmwood Road -21206									
14. FATHER'S NAME FIRST William H. MIDDLE Bryan LAST 					15. MOTHER'S MAIDEN NAME FIRST Lucille C. MIDDLE Griffin LAST 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Joan D. Kimmons		ADDRESS P.O.Box 608 LaPlata, MD. -20646			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL COLONIC CARCINOMA-									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) 									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) MYOCARDIAL INFARCTION.									
19a. DATE OF OPERATION 12/1/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTRIC OUTLET OBSTRUCTION				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that he (this hospital) attended the deceased from 11/24/1987 to 12/5/1987 , that he (we) last saw the deceased alive on 12/5/1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.									
22b. SIGNATURE Loufi Aboussouan						DEGREE		22c. DATE SIGNED 12/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUTFI ABOUSSOUAN				22e. ADDRESS GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-8-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE			
24. FUNERAL DIRECTOR NAME John C. Miller, Inc.-6415 Belair Rd.-21206					25a. DATE RECD. BY REGISTRAR DEC - 8 1987		25b. REGISTRAR'S SIGNATURE Deborah R. Ruddle		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove any staples. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment.

IMPORTANT: If item 21 is marked as "yes," 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

DEC - 8 1987

174251.11-01

NOV 1964

ON FILE

DEC 8 1964

075698 DEC 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOAN S. BUCHNESS					2a. DATE OF DEATH MONTH DAY YEAR 12 / 19 / 87					2b. HOUR 10:30 PM	
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 9 / 9 / 1925			6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Md. Balto					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1104 Frederick Rd 21228				
14. FATHER'S NAME FIRST MIDDLE LAST John L. Sullivan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelia Foster						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-18-7332		17. INFORMANT ADDRESS 1104 Frederick Rd. 21228 Dr. David Buchness							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic Carcinoma of Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>metas to bones.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 900S Caton Ave. Balto. Md 21229					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/87</u> to <u>12/19/87</u> , that (I) (we) last saw the deceased alive on <u>12/19/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>					DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NITIN MAYUR					22e. ADDRESS St Agnes Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/23/87		23c. NAME OF CEMETERY OR CREMATORY Historic Salem Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Sterling Ashton Funeral Estate, P.A. 736 Edmondson Ave 21228					25a. DATE REC'D. BY REGISTRAR DEC 21 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

BP

077153 JAN - 5 88

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34451

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SERGIO ALVES (BUCKNER) JR.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 30, 1987		2b. HOUR 12:59 A
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 12 20 87		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS.	IF UNDER 1 YEAR MONTHS DAYS 10 10
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED	12b. KIND OF BUSINESS OR INDUSTRY N/A	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21213 2136 E. OLIVER STREET	
14. FATHER'S NAME FIRST MIDDLE LAST SERGIO ALVES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THAMATHA BUCKNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. N/A	17. INFORMANT ADDRESS THAMATHA BUCKNER 2136 E. OLIVER ST.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Necrotizing Enterocolitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hours 10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION 12/29/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Necrotizing Enterocolitis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/20/87</u> 19 <u>87</u> to <u>12/30</u> 19 <u>87</u> , that (I) (we) lost the deceased alive on <u>12/30</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Karen Ballaban		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Karen Ballaban		22e. ADDRESS Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/4/88	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL CO. MD	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE		25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

01

075873

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 4 5 2
REG. NO.

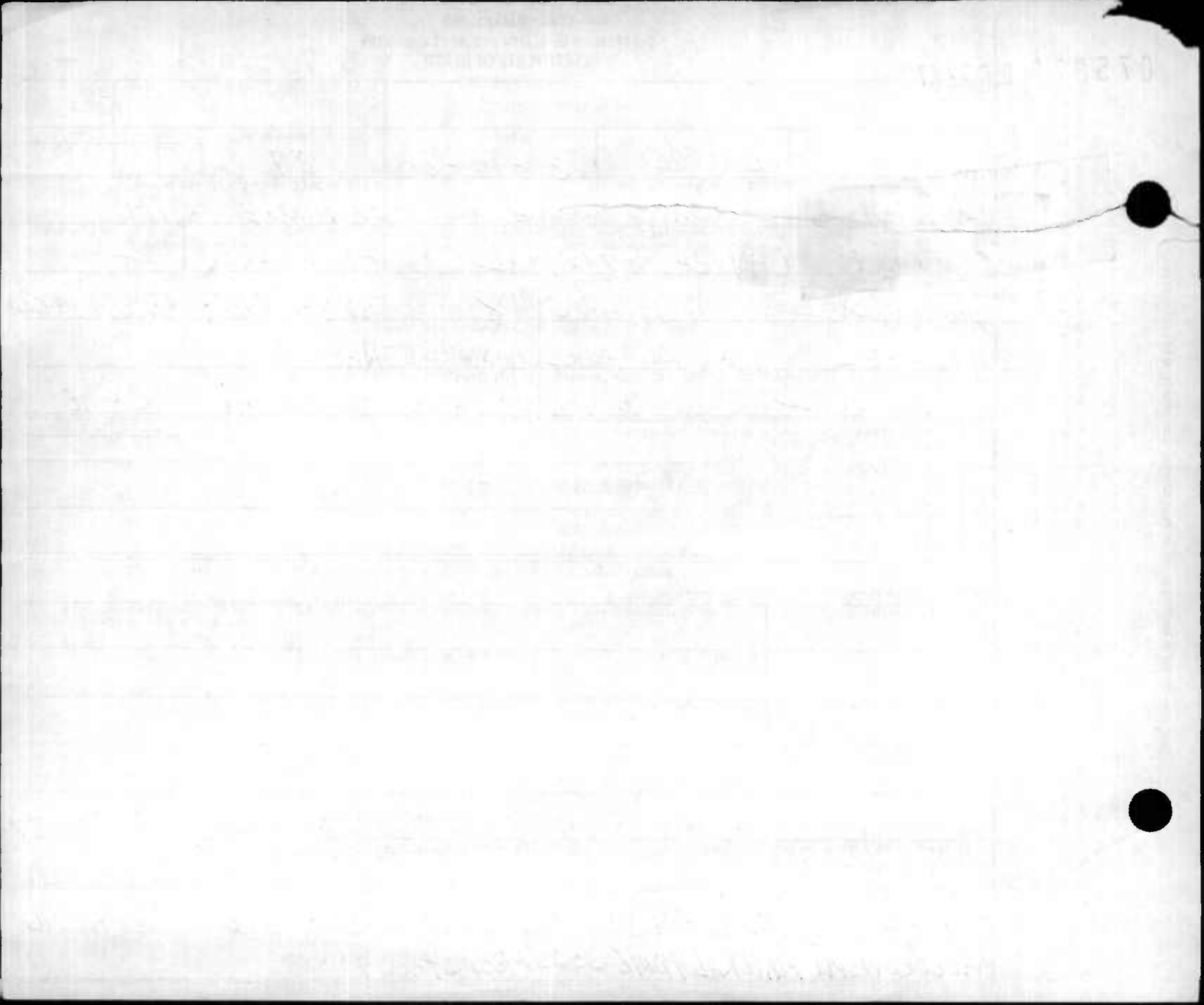
1. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST Mary Budzynski		2a. DATE OF DEATH MONTH DAY YEAR 12 20 87		2b. HOUR 11:38p	
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 3 - 19 - 00	
6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (WHEN IN SUCH FACILITY, GIVE STREET ADDRESS) CHAURCH Hospital		12c. KIND OF BUSINESS OR INDUSTRY	
13a. RESIDENCE (IF MARKING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY MARYLAND BALTIMORE		13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE 9238 Fleet Street 21231	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL MARSZALKIEWICZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGDALENA		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 919-28-2236		17. INFORMANT NAME ADDRESS MR. DANIEL Budzynski SAME		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF HBP? (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Fracture Vertebrae					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE A. R. Nazemi M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.R. Nazemi, M.D.		22e. ADDRESS CHURCH Hospital 100 N. Broadway, Baltimore, Md. 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-23-87		23c. NAME OF CEMETERY OR CREMATORY Holy ROSARY Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		23e. DATE REC'D. BY REGISTRAR DEC 21 1987			
24. FUNERAL DIRECTOR NAME ADDRESS KACOROWSKI FUNERAL HOME 2525 Fleet St		25. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



076089 DEC 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34453

1. DECEASED NAME (TYPE OR PRINT) SARAH C. BUGATCH			2a. DATE OF DEATH MONTH DAY YEAR 12-19 87			2b. HOUR 8:22 AM			
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 06 16 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HEBREW EDUCATOR		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7508 SLADE AVE. #21208	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN CHODOSH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT MICHAEL FREILICH, ATTY. 408 BOSLEY AVE., TOWSON, MD 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jeri Selva				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-19-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERI SELVA				22e. ADDRESS Sinai hosp of Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-21-87		23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESED		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALSTOWN BALTO MD			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 23 1987					

MEDICAL CERTIFICATION

97
92
33
30
22
9

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

10-15-2014

ИДЯД:

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

050330

076050 DEC 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34454

1. DECEASED NAME (TYPE OR PRINT) Doris Marie Bullen			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1987			2b. HOUR 6:15 p.m.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 8 29		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 16 S. Eleanor Avenue 21090	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert M. Gosnell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Warfield					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-26-0386		17. INFORMANT ADDRESS 21090 Oliver E. Bullen, Jr. 16 S. Eleanor Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Metastatic Bronchogenic Cancer, Chronic Renal Failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 14,</u> 19 <u>87</u> , to <u>Dec. 20,</u> 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 20,</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) (do not) view the body after death.									
22b. SIGNATURE <u>H. Ghandour</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Hassan Ghandour</u>				22e. ADDRESS Maryland General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/23/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR DEC 23 1987		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

1

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "no", the medical examiner must be notified at once.

DATE: JANUARY 10

TIME: 10:00 AM

TO: Mr. J. H. [illegible]

FROM: [illegible]

076256 DEC 28 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 3 4 4 5 5

1. DECEASED NAME (TYPE OR PRINT) <u>Clarence Webster Bunting</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>10</u> : <u>21</u> : <u>87</u>		2b. HOUR <u>2:35 A M</u>
3. SEX <u>M</u>	4. RACE <u>CAUCASIAN</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>5</u> <u>18</u> <u>11</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTD. CITY</u> MD.	
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>NORTH CHARLES GEN. Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Silversmith</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u>
13a. STATE <u>MD.</u>			13b. COUNTY <u>BALTIMORE</u>	13c. CITY OR TOWN <u>BALTIMORE</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Clarence Pohl Bunting</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ada Jones</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>215-01-7062</u>		17. INFORMANT ADDRESS <u>Mrs. Anne Shearer 4 Upland Road 22210</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Atherosclerotic heart disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/12/1987</u> to <u>12/21/1987</u> , that (I) (we) last saw the deceased alive on <u>12/21/1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>12-21-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. [Signature]</u>		22e. ADDRESS <u>North Charles Hosp. / Baltimore MD 21248</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/23/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</u>			25a. DATE REC'D. BY REGISTRAR <u>DEC 24 1987</u>		
			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

35
39
35
300
1
2
9
1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Y. 2. 1. 3. 3. 4. 1

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 3 4 4 5 6

FOR
1- STATE
REGISTRAR

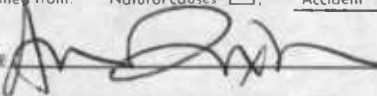
| | | | | | | | | | | | |
|--|--|--|--|---|--------------------------------------|---|---|----------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
BARRY BURG | | | 2a. DATE KNOWN OF DEATH
ESTIMATED MONTH DAY YEAR
12 8 19 87 | | | 2b. HOUR
M
10:32 PM | | | | | |
| 4. RACE
MALE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 13, 1951 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) MONTHS DAYS HOURS MIN
36 YRS | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 8 19 87 | | 7d. HOUR
M
10:32 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital (STU) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
C LINICAL THERAPIST - DRUG | | | 12b. KIND OF BUSINESS OR INDUSTRY
REHABILITATION | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
Charles | | 13c. CITY OR TOWN
NANJEMOY | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
20643 LIVERPOOL RD. P.O. BOX 205 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
IRVING BURG | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NORMA ERSHOWSKI | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
10003 | | |
| 17. INFORMANT
MICHAEL BURG | | | 18. ADDRESS
431 E. 9th St. N.Y.C.NY | | | | | | | | |

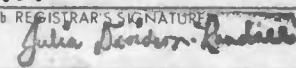
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR MIN MONTH DAY YEAR
8:15 P.M. 12-8-1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Driver of auto/auto collision. | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Md. Rt. 16 so. of Dorchester, MD | |

22a. I certify that I took charge of the remains described above, held an autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE  TITLE (SPECIFY) **Deputy Chief** MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) **Ann M. Dixon, M.D.** ADDRESS **111 Penn St., Balto., MD 21201**
DATE SIGNED **12-9-87**

| | | | | | | | |
|---|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PARAMUS, N.J. | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS.
6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | | 25b. REGISTRAR'S SIGNATURE
 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL WITHIN 1 B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

072515 DEC 1971

...

.....

[Handwritten signature]

072515 DEC 1971

075293 DEC 17 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34457

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Henry Burgess | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 12, 1987 | | | 2b. HOUR
2:32pM | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 18 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NA | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1401 LAKEWOOD AVENUE 21213 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
RICHMOND BURGESS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZABETH MILLS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | | | 16b. SOCIAL SECURITY NO.
216-16-9674 H | | 17. INFORMANT
ADDRESS
ELIZABETH BURGESS 1401 LAKEWOOD AVENUE APT 328 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Bradycardia</u>
(c) <u>Metastatic Lung Cancer</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 11, 1987</u> to <u>Dec. 12, 1987</u> , that (X) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Shab shab | | | | 22e. ADDRESS
Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST VET CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | | | 25. DATE REC'D BY REGISTRAR 26. REGISTRAR'S SIGNATURE
DEC 16 1987 <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

076867 DEC 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 4 4 5 8

| | | | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|-------------------------|--|--------------------------|--|----------|--|
| 1. DECEASED NAME
(TYPE & PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Edwin | | B. | | Burhorst | | | | X | | 12-28-87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| MALE | WHITE | MAY 19 1932 | | 55 YRS. | | MONTHS DAYS HOURS MIN. | | | | 12-28-1987 | | 9:11P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MARYLAND | | U. S. A. | | | | Baltimore City | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | Francis Scott Key Medical Center | | DRIVER | | P.J.A.X. Co. | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4505 VALLEY VIEW AVE. | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| EDWARD B. BURHORST | | ELIZABETH CHESTER | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| NO | | 216 28 1186 | | FAMILY RECORDS | | | | | | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | | | |
|---|--|--|--|---|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY)
M.D. <u>Assistant</u> MEDICAL EXAMINER | | DATE SIGNED <u>12-29-87</u> | |
| ACTUAL SIGNATURE
<u>Charles P. Kokes</u> | | EXAMINER'S NAME
(TYPE OR PRINT) <u>Charles P. Kokes, M.D.</u> | | ADDRESS <u>111 Penn Street, Baltimore, MD 21201</u> | |

| | | | | | | | |
|---|--|-------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | JAN. 2 1988 | | Moreland Mem. Pk. | | PARKVILLE BALTO. MD. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| EVANS CHAPLOF MEMORIES | | 8800 HARFORD ROAD | | DEC 31 1987 | | <u>[Signature]</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 2, 3, AND 4. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (15))

1318 334 570 850

075430 DEC 10 1987

Item 18d, b, 20, 22a, G635 1-18-88 dw

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR per med exam

1- REGISTRAR G641, 18a, 7-12-88

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4459

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Dominic

Burke

2a. DATE KNOWN OF DEATH ESTI-
MATED ☒ 12-10-87 12-10-87

3 SEX

Male

4 RACE

Black

5 DATE OF BIRTH

6/4/79

YEAR

6 AGE (IN YEARS
(LAST BIRTHDAY))

8 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR

12-10-87

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

459 Yale Avenue

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Student

12b. KIND OF BUSINESS
OR INDUSTRY

School

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

459 Yale Ave. 21229

14. FATHER'S NAME

Glenn

MIDDLE

Smith

LAST

15. MOTHER'S MAIDEN NAME

Evelyn

MIDDLE

Burke

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

218-92-8912

17. INFORMANT

ADDRESS

Evelyn Burke 459 Yale Ave. 21229

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Chronic bronchitis and Seizure disorder

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) Congenital hydrocephalus

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 12-10-87

EXAMINER'S NAME
(TYPE OR PRINT)

Charles P. Kokes, M.D.

ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12/16/87

23c. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

23d. LOCATION
CITY OR TOWN

Arbutus

COUNTY

Md.

STATE

24. FUNERAL DIRECTOR

NAME Estep Bros. F.H. 1300 Eutaw Pl.

25a. DATE REC'D. BY REGISTRAR

DEC 17 1987

25b. REGISTRAR'S SIGNATURE

Julia Anderson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25MDHMH - 17
(VR A15 ME (5))

012 30 DEC 1981

13617 MOTION PICTURE

END

1000

11

10

00

00

00

31

075436 DEC 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34460

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Helen R. Burns | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 15 87 | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 12 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5903 Ayleshire Rd. 21239 | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anthony F. Hild | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Kelly | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-50-5983 | | 17. INFORMANT
ADDRESS
Miss. Helen M. Burns Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION / CVA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HOURS. | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from MAY 19 85 to DEC 19 87, that (1) (we) lost
saw the deceased alive on 12/30 19 87, and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | | | | 22c. DATE SIGNED
12/16/87 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
James Kleeman M.D. | | | | 22e. ADDRESS
7600 Osler Dr. 21204 | | | | 22d. DATE SIGNED
12/16/87 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. 1050 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1987 | | 25b. REGISTRAR'S SIGNATURE
Lia. Landon-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

075105 DEC 15-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 4 4 6 1

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Wilbert Burnett | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 87 | | 2b. HOUR
3:51 AM |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
10 13 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BETH STEEL | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2602 AISQUITH STREET 21218 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM BURNETT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARTHA ROBERTSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | 16b. SOCIAL SECURITY NO.
239-12-4196 | 17. INFORMANT
ADDRESS
LIZZIE BURNETT 2602 aisquith street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CORONARY ARTERY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
<u>Peripheral vascular Disease</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> , 19 <u>87</u> , to <u>12/18</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12/18/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Mark A. Hagan</u> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. BURNETT HANAGAN | | | | 22e. ADDRESS
2706 North Charles Street
Baltimore MD 21218 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/16/87 | 23c. NAME OF CEMETERY OR CREMATORY
CHURCH CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WINDSOR, NC |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Anderson-Randall</u> | | |

MEDICAL CERTIFICATION

9
9

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP _____

2020 COTTON FIRE

UNIVERSITY

DOWN



012105 121201

076574 DEC 87 OR
DATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34462
REG. NO.

| | | | | | | |
|--|--|---|--|---|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Annie MAE Burrell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 24 87 | | 2b. HOUR
10:20 AM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 12 11 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 8. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mt. Vernon Care Center | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE
Maryland | | |
| 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
2019 Druid Hill Avenue, 21217 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
DANIEL MACK Williams | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Flora Hayden | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
unknown | | 16b. SOCIAL SECURITY NO.
216-28-9426 | | 17. INFORMANT
Joan Williams | | |
| 17. ADDRESS
3310 Woodripple Rd. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD
DUE TO, OR AS A CONSEQUENCE OF (b) COPD
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
A. Chatterjee DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. CHATTERJEE | | 22e. ADDRESS
Mt. Vernon Nursing Home | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F.H. West 4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DEC 3 8 1911

2022 MILLER 11222

2010

2010 11222

2010 11222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

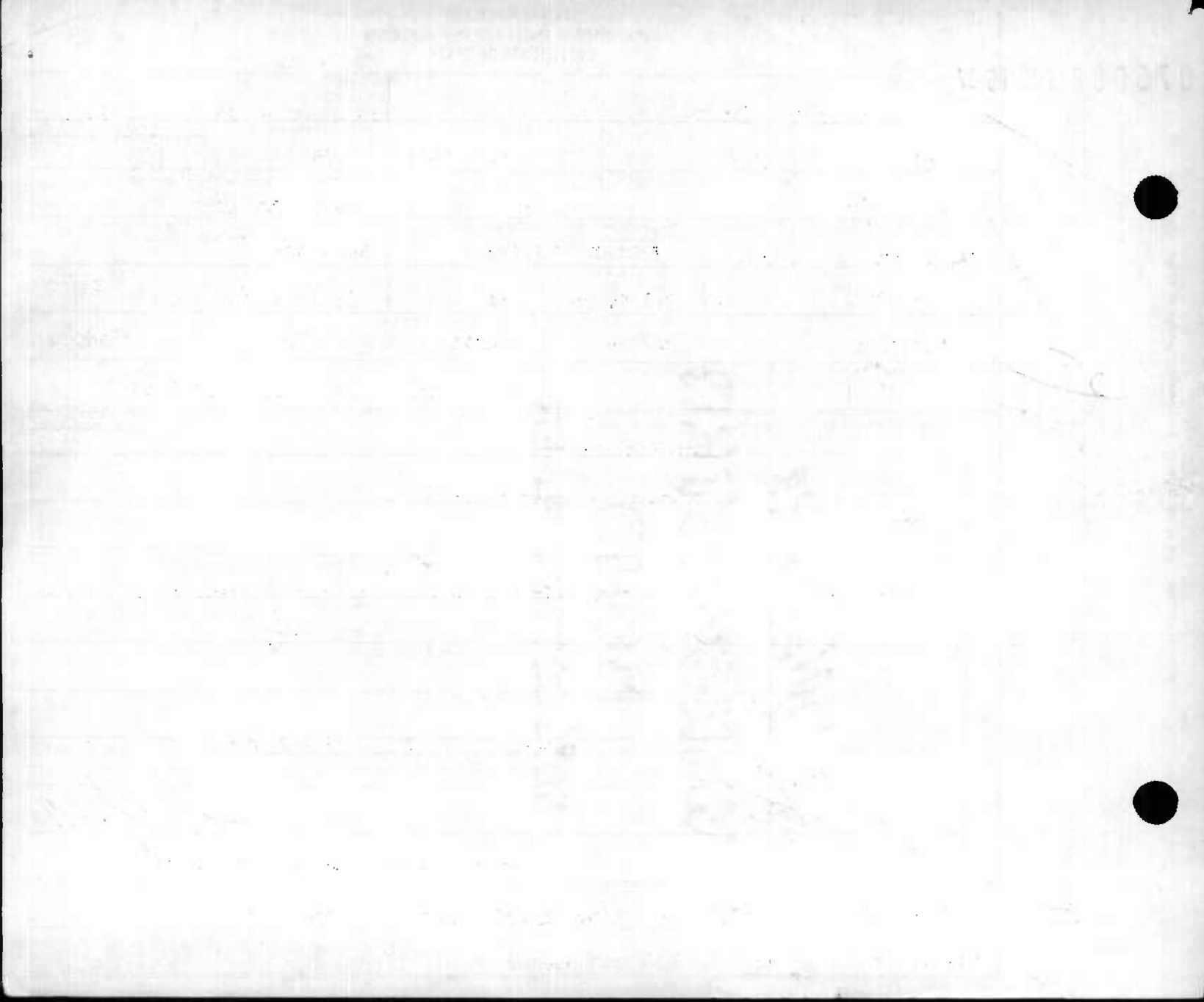
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34463
REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JUANITA Budden EUSE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 8, 1987 | | 2b. HOUR
9:30 PM |
| 3. SEX
female | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
2 17 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | 7b. CITIZEN OF WHAT COUNTRY?
U S A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Adorphus Budden | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah E. McFadden | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Sarah Mack 2604 Allendale Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Hypertension, Diabetes Mellitus, Cardiovascular Accident, Carcinoma of Breast | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 11, 1987 , to December 8, 1987 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on December 8, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
 | | DEGREE | | 22c. DATE SIGNED
12/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/15/87 | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown Md |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H West 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1987 | | 25b. REGISTRAR'S SIGNATURE
 | |

BP 2



076741 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 1, 2, and 3 and 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GERTRUDE A. BUSICK | | | | | 2a. DATE OF DEATH
MONTH 12 DAY 27 YEAR 87 | | 2b. HOUR
3:10 a.m. | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 7 DAY 21 YEAR 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1803 Northbourne Rd. 21239 | | |
| 13a. STATE
MD. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | | | | |
| 14. FATHER'S NAME
FIRST Louis MIDDLE Langhirt LAST Langhirt | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Marie MIDDLE Mueller LAST Mueller | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-24-0224 | | 17. INFORMANT
ADDRESS
John H. Busick (husband) same address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ALCOHOL ABUSE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
12/25 | | CITY OR TOWN
12/27 | | COUNTY
1987 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25 , 19 87 , to 12/27 , 19 87 , that (I) (we) lost
saw the deceased alive on 12/27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Tullio Emanuele | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/27/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TULLIO EMANUELE | | | | | 22e. ADDRESS
5601 LOCH RAVEN BLVD
BALTIMORE MD 21239 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/30/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION
CITY OR TOWN
BALTIMORE | | COUNTY
MD. | |
| 24. FUNERAL DIRECTOR
SCHLUNKER FUNERAL HOME, INC. | | | | | 9705 Belair Road
Balto. Md. 21236 | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

00101

SECTION 1
SHEET 1
4P 100 of 100

AMERICAN

1000 + 1000 + 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP 11

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34466

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Edith Butler</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>December 15 1987</i> | | 2b. HOUR
<i>6:15 A.M.</i> |
| 3. SEX
<i>female</i> | 4. RACE
<i>black</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 22 1912</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<i>75</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>D. C.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U S A</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore, City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Md General Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>Md</i> | | | 13b. COUNTY
<i>Baltimore</i> | 13c. CITY OR TOWN
<i>Baltimore</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>John Williams</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Clara Jupiter</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>212-20-4482</i> | | 17. INFORMANT
ADDRESS
<i>Bernard L. Shade 6721 Town Brook Drive</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <i>Anoxic Brain Injury</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Severe Asthma</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>10</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>November 24</i> , 19 <i>87</i> , to <i>December 15</i> , 19 <i>87</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>December 15</i> , 19 <i>87</i> , and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Donaten H. Maecem</i> | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/15/87</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>AMATUN N MAEEM</i> | | | 22e. ADDRESS
<i>C/O Maryland General Hospital</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/18/87</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arbutus Memorial</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Arbutus Md</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Wm. C. March F/H West</i> | | | ADDRESS
<i>4300 Wabash Avenue</i> | | 25. DATE REC'D. BY REGISTRAR
<i>DEC 18 1987</i> |
| | | | 26. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | |

RECEIVED
FEB 10 1964

12-12-63

12-12-63

12-12-63

12-12-63

12-12-63

DEC 1 1963

076340 DEC 28

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34467
REG. NO

| | | | | | |
|---|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GLORIA A. BUTLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 15, 1987 | | 2b. HOUR
10:50 pm |
| 3. SEX
Female | 4. RACE
Negro | 5. DATE OF BIRTH
MONTH DAY YEAR
4-10-1933 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
54 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md | 7b. CITY OR TOWN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
517 Pressman St 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel Jordan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Wilson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-34-5121 | | 17. INFORMANT
NAME ADDRESS
Mrs. Mary Jordan 517 Pressman St 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) INTRACRANIAL BLEEDING (Intra cerebellar)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Thrombocytopenia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
HYPERTENSION, ALCOHOL ABUSE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) (this hospital) attended the deceased from DECEMBER 15, 1987 , to DECEMBER 15, 1987 , that (I) (we) last saw the deceased alive on DECEMBER 15, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE
J. Azar | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John Azar | | 22e. ADDRESS
c/o MARYLAND GENERAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-19-87 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph L. Russ 2222 W. North Ave | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Benson-Rodner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1850 31 23 10

[Faint, illegible handwriting on lined paper, possibly a ledger or account book. The text is mostly obscured by fading and bleed-through.]

[Faint text at the bottom of the page, possibly a signature or footer.]

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 3 4 4 6 8

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
IRVIN L. BUTLER | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 21 1987 | | 2b. HOUR
6:12 A.M. |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH MONTH DAY YEAR
1 24 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO. MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GEN. Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
UNKNOWN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-01-0460 | | 17. INFORMANT ADDRESS
Miss Penny Alexander 1114 Cathedral St | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pulmonary edema</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of prostate</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Dementia Bil. CVA & Bil. Hemiplegia.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/13/87</u> , 19 <u>87</u> , to <u>12/21/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/21/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>[Signature]</u> | | 22e. ADDRESS
<u>North Charles Hospital Baltimore MD 21218</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
B | 23b. DATE
12/28/87 | 23c. NAME OF CEMETERY OR CREMATORY
Catholics near Mt | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1987 | |
| 24. FUNERAL DIRECTOR
NAME
<u>Joseph C. Purns</u> | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

MEDICAL CERTIFICATION

07633

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (copy) be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

07039
4

McGraw

076788 DEC 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34469

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
PEARL B BUTLER | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/27/87 | | 2b. HOUR
3-25-M | |
| 3. SEX
F | | 4. RACE
B 2 | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/9/06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
V.I.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MD | | 13c. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2609 Oakley Avenue 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tennis Edwards | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Goodman | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-74-4242 | |
| 17. INFORMANT
Dr Sangani | | ADDRESS
Sinai Hospital, Baltimore MD | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure (CHF)
DUE TO, OR AS A CONSEQUENCE OF
(b) Ischemic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr Sangani | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr Sangani | | | | 22e. ADDRESS
Sinai Hospital, Baltimore, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
12/31/87 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NAT. Cem. | | 23d. LOCATION
BALTO. COUNTY MD | |
| 24. FUNERAL DIRECTOR
BETHS FUNERAL HOME | | | | 25a. DATE RECD. BY REGISTRAR
DEC 29 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

7/23/50

10/2/50

RECEIVED
FEB 11 1951

CONFIDENTIAL

SECRET

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 4470

| | | | | | | | | | | | | | | | |
|---|--|---------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR
DECEASED NAME (TYPE OR PRINT) George S. Byrd | | | | | | | | | | 2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 12-25-87 | | 2b. HOUR M 12:15 | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 22 1951 | | 6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 12-26-1987 | | 7d. HOUR M 12:15 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4902 Lanier Avenue | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY Pimlico Race Track | |
| 13a. STATE Md | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4902 Lanier Avenue 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jennings Byrd | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Grimes | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 215-48-8915 | | | | 17. INFORMANT Helen Byrd | | | | ADDRESS 4916 Poe Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Narcotic intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-25 19 87 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject took drugs | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4902 Lanier Avenue, Baltimore City, Maryland | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles P. Kokes | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 12-27-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/4/88 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | | | 23d. LOCATION CITY OR TOWN Arbutus | | COUNTY | | STATE Md | |
| 24. FUNERAL DIRECTOR NAME Wm. c. March F/H West | | | | ADDRESS 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JAN 4 1988 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

000000 000000

20% COTTON FIBER

MADE IN U.S.A.



075780 DEC 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34471

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| FOR STATE REGISTRAR | | | | 87 REG. NO. 34471 | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Evelyn Cain | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 7 87
2b. HOUR
6:20 AM | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 4 47 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
STATE OR FOREIGN COUNTRY
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse ph. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
Talbot | | 13c. CITY OR TOWN
EASTON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
10 PRICE ST. 21601 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
LEWIS Campher | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hilda Campher | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
219-46-4980 | | 17. INFORMANT
Norris Cain Sr | | 18. ADDRESS
10 Price St. Easton Md 21601 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiorespiratory failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) brain death
DUE TO, OR AS A CONSEQUENCE OF
(c) ruptured cerebral aneurism | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 12/7/87 to 12/7/87 , 19 87 , that (I) (we) last saw the deceased alive on 12/7/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b. SIGNATURE
Brad A. Trommen DEGREE MD | |
| 22c. DATE SIGNED
12/7/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRAD A. Trommen | | 22e. ADDRESS
22. S. Greene St BART, MD | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
B | | 23b. DATE
12/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Powder Mill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Tempe Tal MD | |
| 24. FUNERAL DIRECTOR
NAME
Em D. Daulton | | 24b. ADDRESS
PO Box 608 | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1987 | | 25b. REGISTRAR'S SIGNATURE
Em D. Daulton | |

MEDICAL CERTIFICATION

073996 DEC -3

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34472

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELIZABETH CALANDRIELLO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 1 87 | | 2b. HOUR
6:58 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 8 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Randellstown | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
9056 Meadow Heights Rd. 21133 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vincent Cappucci | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura Scalzo | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
057-26-1934 | | 17. INFORMANT
Miss Annette Calandriello Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/8, 1987, to 12/1, 1987, that (I) (we) lost saw the deceased alive on 12/1, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
HANI SHANKHAN | | DEGREE
MD | | 22c. DATE SIGNED
12/1/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
SINAI HOSPITAL DC BALTO | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/1/87 | 23c. NAME OF CEMETERY OR CREMATORY
St. Johns Cemetery | | 23d. LOCATION
Middle Village Queens N.Y. | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. | | ADDRESS
21204 1050 York Rd. | | 25. DATE REC'D. BY REGISTRAR
DEC 03 1987 | |

MEDICAL CERTIFICATION

9
9

BP

DHMH: 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

CO₂ RELEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 4 4 7 3
REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | |
|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Nunzio J. Cammarata | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 1987 | | 2b. HOUR
8:35 PM | |
| 3. SEX
M | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
01 - 26 - 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Cammarata | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Tumminello | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII 218-05-9556 | | 17. INFORMANT
ADDRESS
Marion L. Cammarata, Same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Metastatic Bladder carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/05/87</u> to <u>12/26/87</u> , that (I) (we) last saw the deceased alive on <u>12/26/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>S. Kamal</u> | | DEGREE
<u>MBBS</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12/26/87</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>S. KAMAL</u> | | 22e. ADDRESS
<u>SINAI HOSPITAL</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>12-30-87</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Dulaney Valley</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Cockeysville Md.</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 29 1987</u> | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John Gordon-Rodell</u> | | |

MEDICAL CERTIFICATION

BP

074514 DEC-9

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34474
REG. NO.

| | | | | | | |
|---|--|---|---|--|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GUSTAVIA S CAMPBELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 6 / 87 | | 2b. HOUR
9²² AM | |
| 3. SEX
F | | 4. RACE
B V | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 18 63 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
24 YRS | | 7. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ironer | | 12b. KIND OF BUSINESS OR INDUSTRY
Laundry Press | | 13a. STREET ADDRESS
427 Mosher St. | | |
| 13b. COUNTY
Md. | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nathan Middleton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Irene Campbell | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
212-88-2783 | | 17. INFORMANT
ADDRESS
Margaret Parish 427 Mosher St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) SARCOID
DUE TO, OR AS A CONSEQUENCE OF
(c) PULMONARY HYPERTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: IMMEDIATE
DIAGNOSED 1 YEAR AGO | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (this hospital) attended the deceased from 12/2 , 19 87 , to 12/6 , 19 87 , that (we) lost
saw the deceased alive on 12/6 , 19 87 , and that in (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Wm. J. P. Still | | DEGREE
MD | | 22c. DATE SIGNED
12/6/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William J. P. Still | | 22e. ADDRESS
22 S. GREENG ST. BALT. MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK)
BURIAL | | 23b. DATE
12/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | |
| 23d. LOCATION
(CITY OR TOWN)
Balto | | COUNTY
Md. | | STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Jas. A. Morton & Sons | | ADDRESS
1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR
DEC - 8 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

20% coupon 11-11-11

11-11-11

11-11-11

11-11-11

075451 DEC 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 4 4 7 5

| | | | | | | | | | | | | | |
|--|---------|---|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Lucille E. Campbell | | | | | | | | XX 12-13 1987 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| female | black | 1 13 1914 | | 73 YRS. | | | | | | 12-13 1987 | | 1:40 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md | | U S A | | WIDOWED | | DIVORCED | | Baltimore City, | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | 3013 Spaulding Avenue | | Retired | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md | | | | Baltimore | | YES X NO | | 3013 Spaulding Avenue | | | | 21215 | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | |
| Charles | | | | Haycock | | Emma | | | | Watts | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 215-12-7858 | | Charlotte Gray | | 3013 Spaulding | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>Diabetes Mellitus, Alzheimer's Disease</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | |
| | | | | YES NO XX | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <u>Accident</u> <u>Suicide</u> <u>Homicide</u> <u>Undetermined manner</u>
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | |
| <i>Mario F. Golle, Jr.</i> | | M.D. Assistant | | 12-14-87 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | |
| Mario F. Golle, Jr., M.D. | | 111 Penn St., Balto., Md. | | 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | | | |
| Burial | | 12/18/87 | | Arbutus Memorial Park | | Arbutus | | | | Md | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Wm. C. March F/H West | | 4300 Wabash Avenue | | DEC 17 1987 | | <i>[Signature]</i> | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

012421 FEB 1963



WIND

WINTER

80% COTTON 20% WOOL

DEC 15 1962

DEC 3 9 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34477

| | | | | |
|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lillian Campher | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/24/87 | | 2b. HOUR
7:00 PM |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
9 10 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KESWICK NURSING HOME | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSE KEEPER | 12b. KIND OF BUSINESS OR INDUSTRY
PVT. FAMILY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
700 W. 40TH ST. BALTO. MD. 21211 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM CAMPHER | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALICE BANKS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO. | 16b. SOCIAL SECURITY NO.
150-22-1122 | 17. INFORMANT
BALTIMORE, MD.
O. ROBERT CAMPHER 3612 DENNLYN RD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Atherosclerotic coronary disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 mins
years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Hypertension - Dehydration | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (if this hospital) attended the deceased from 4-3 19 85 to Dec 24 19 87, that (I) (we) last saw the deceased alive on 24 Dec 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
J. S. W. ZEBLEY MD | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. S. W. ZEBLEY MD | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
12/31/1987 | 23c. NAME OF CEMETERY OR CREMATORY
ARBUS MCM. PARK | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | |
| 24. FUNERAL HOME FOR NAME
FUNERAL HOMES, INC.
2501 GWYNNS FALLS PKWY, BALTO, MD. 21216 | | 25a. DATE REC'D BY REGISTRAR
DEC 29 1987 | | |
| | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1905 DEC 30 61

2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4478

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|---------|---|--|--|----------------|---|------------------|---|--------------------------|---|--|--|-----------|-------------------|--|---|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | | | | | |
| Esther | | Caplan | | | | | | DATE ESTIMATED <input checked="" type="checkbox"/> 12 4 19 87 | | | | 10:48 a M | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | | 7d. HOUR | | | | | | |
| FEMALE | WHITE | 4/20/09 | | 78 | MONTHS | | DAYS | | 12 7 87 | | | | 10:48 a M | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| MARYLAND | | USA | | | | Baltimore City | | | | MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | 6040 Green Meadow Pkwy | | | | CLERK | | | | BALTO. CITY | | | | | | | | | |
| 13a. STATE | | | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | | | | | | | | | | | | | BALTIMORE | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 6040 GREEN MEADOW PKWY (21209) | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| SIMON | | | | | | CAPLAN | | | | | | REBECCA LEVIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | |
| NO | | | | | | | | JULIUS CAPLAN | | | | COCONUT CRK. FL 2606 NASSAU BEND RD. 33066 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| Mario F. golle, Jr, M.D. | | | | 111 Penn St. | | | | Balto.MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| BURIAL | | | | 12/10/87 | | PETACH TIKVAH CEM | | | | ROSEDALE, BALTO. MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | | DEC 15 1987 | | | | Julia Decker-Rudner | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

052510 DEC 1983



Q331A-MOTION-XPO3

Q331A-MOTION-XPO3

Q331A-MOTION-XPO3

DEC 12 1983

76184 DEC 28 1987

2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 15

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

35
48
300
1
2
9
1

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Charles Carghill</i> | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>December 16, 1987</i> | | | 2b. HOUR
<i>2:45 P.M.</i> | | | |
| 3. SEX
<i>M</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>7 1 99</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
<i>88</i> | | IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City MD</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Maryland General Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<i>MD.</i> | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>3706 Nortonia Rd. 21216</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>UNKNOWN</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>UNKNOWN</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>219-54-3738</i> | | 17. INFORMANT
ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Multiple decubiti; Malnutrition</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Cachexia</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23a. SIGNATURE
<i>Harry M. Harris</i> | | | | | | DEGREE
<i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/18/87</i> | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Harry M. Harris, M.D.</i> | | | | | | 22e. ADDRESS
<i>c/o Maryland General Hospital</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
<i>BURIAL</i> | | | 23b. DATE
<i>12/30/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt Zion</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Jeff Miller F.H.</i> | | | | | | ADDRESS
<i>1639 N Broadway</i> | | 25. DATE REC'D. BY REGISTRAR
<i>DEC 24 1987</i> | | | |
| | | | | | | | | 26. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

1917

1917

1917

1917

1917

1917

1917

1917

1917

DEC 24 1917

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34480
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Louis Robert Carguil | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 26, 1987 | | | 2b. HOUR
4:00 P.
M. | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MO DAY YEAR
05 06 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Priest | | 12b. KIND OF BUSINESS OR INDUSTRY
Religious | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6420 East Pratt St. 21224 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Moses Thomas Carguil | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Phoebe Wedge | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes Korea | | | | 16b. SOCIAL SECURITY NO.
072-22-9410 | |
| 17. INFORMANT
ADDRESS
Rev. Thomas Sinconolli C.S.S.R. 6420 E. Pratt | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Schemen Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. C. Kowalewski MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12-28-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. C. Kowalewski MD | | | | | | 22e. ADDRESS
8604 HARFORD PL. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-31-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Saint Alphonsus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ulster Co., N.Y. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. | | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | | | | |
| ADDRESS
6224 Eastern Ave. | | | | | | REGISTRAR'S SIGNATURE
John D. Darden | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

[Faint, illegible handwritten notes]

2-15-51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
GEORGE LETHEN CARMEN | | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 30 1908 | | 6a. DATE OF DEATH MONTH DAY YEAR
12 13 1987 | | 6b. HOUR
10.15am | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Food Broker | | 12b. KIND OF BUSINESS OR INDUSTRY
Food | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Parkville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2916 Kings Ridge Road 21234 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Carmen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mattie Knight | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
212-10- 9014 | | 17. INFORMANT ADDRESS
Mary B. Carmen 2916 Kings Ridge Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UNKNOWN, PULMONARY EMBOLUS SUSPECTED
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) COLON SURGERY
DUE TO, OR AS A CONSEQUENCE OF
(c) COLON CANCER
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a
HYPERGLYCEMIA; HYPERTENSION | | | | | | | | | |
| 19a. DATE OF OPERATION
11/18/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
COLON CARCINOMA | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 11/17 , 19 87 , to 12/13 , 19 87 , that (I) (we) last saw the deceased alive on 12/13 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
 | | | | DEGREE | | | | 22c. DATE SIGNED
12/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JEAN-PIERRE ISSA MD | | | | 22e. ADDRESS
5801 Loch Raven Blvd Balto Md 21234 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-16-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Evan. Luth. Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto. Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Leonard J. Ruck, Inc. | | | | ADDRESS
5305 Harford Rd. | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1987 | | 25b. REGISTRAR'S SIGNATURE
 | |

BP

072882 170100

12 12 1974 10:10A
GEORGE LAMARCA

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

12 12 1974 10:10A

074697 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 4 8 2
REG. NO.

| | | | | | | | |
|--|--|--|---|---|------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Rose Caro</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>12 8 87</u> | | 2b. HOUR
<u>6:15</u> A.M. | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>02 12 1896</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<u>91</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Boston, Mass</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore City</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Levindale Geriatric Home & Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Domestic</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<u>MD</u> | | 13b. COUNTY
<u>Howard</u> | | 13c. CITY OR TOWN
<u>Columbia</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Louis Bennett</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Gertrude Mayer</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>022-12-9440</u> | |
| 17. INFORMANT
ADDRESS
<u>Barrington, R.I.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>UPPER GASTROINTESTINAL BLEED</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CHRONIC NAUSEA AND VOMITING</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>INABILITY TO SWALLOW</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 Days</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>END-STAGE PARKINSON'S DISEASE, RECURRENT ASPIRATION PNEUMONIA</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>6-13-74</u> to <u>12-8</u> , 19 <u>87</u> , that (1) <u>we</u> lost saw the deceased alive on <u>12-8-87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (2) we (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>A. J. Lucco</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12-8-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>A. J. Lucco</u> | | 22e. ADDRESS
<u>2434 W. BELMONT AVE</u> | | BALTIMORE
<u>21215-5399</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>12-10-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Adath--Jerusalem Cem.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>West Roxbury, Suffolk, Mass.</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>Marzullo Funeral Service</u> | | ADDRESS
<u>Upperco, MD.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 10 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please immediately return page 3 to the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above shows injury, or other traumatic event, the medical examiner must be notified at once.

074000 DEC 11 1964

RECEIVED

NOV 11 1964

RECEIVED
NOV 11 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 34483

075520 DEC 18 1987

| | | | | | |
|---|---|--|---|---|------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | M | |
| Donna Mae Carr | | 12-14-87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Female | White | 2 18 1927 | 60 YRS. | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Ohio | U.S.A. | | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Francis Scott Key Medical Center | BelAir Nursing Hm. | | Aid | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4320 Clareway Apt 50 21213 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | | |
| Walter Carr | Viola Makin | | 7534 Ives Lane Baltimore, Md. 21222 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS | |
| No | 220-22-6845 | Dorothy Roberts | | Baltimore, Md. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a). <u>Head and chest injuries</u> | | | | | |
| DUETO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. | | | | | |
| (b) _____ | | | | | |
| DUETO, OR AS A CONSEQUENCE OF | | | | | |
| (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| | | 12:45PM 12-6-87 | | Pedestrian struck by auto | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | road | | Mayfield and Belair Road intersection, Baltimore City, MD | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| | | Assistant | | 12-15-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Charles P. Kokes, M.D. | | 111 Penn Street, Baltimore, MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 12-16-87 | Moreland Memorial | Baltimore City, Maryland | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Duda-Ruck, Inc. 7922 Wise Ave. Balto Md. 21222 | | DEC 18 1987 | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

0123456789



12 14 16 18 20 22 24 26 28 30 32 34 36 38 40 42 44 46 48 50 52 54 56 58 60 62 64 66 68 70 72 74 76 78 80 82 84 86 88 90 92 94 96 98 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____
DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 4 4 8 4
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ANNA MARY CARTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 29 87 | | 2b. HOUR
11:00 P.M. | | | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 1 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DELTA, PENN | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 12. CITY OR TOWN OF DEATH
Balto City | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Agnes Hospital | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 15. KIND OF BUSINESS OR INDUSTRY
N/A | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
138 S. MORLEY ST. 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
STEVEN MURRAY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELSIE SWEENEY | | | 16. ADDRESS | | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 17b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17c. SOCIAL SECURITY NO.
196 16 9849 | | 18. INFORMANT
LINDA OWENS 2821 WHITEFORD RD. 21160 | | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypoxia</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Hypercoagulable syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 wks
5 wks | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pulmonary embolism</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-6-87</u> , 19____, to <u>12-29-87</u> , 19____, that (I) (we) lost
saw the deceased alive on <u>12-29-87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23a. SIGNATURE
<u>Paul E. Gormley</u> | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 23b. DATE SIGNED
12/29/87 | | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul E. Gormley | | | | 23d. ADDRESS
900 Cotton Ave Balto. Md 21229 | | | | | | |
| 23e. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23f. DATE
1/2/88 | | 23g. NAME OF CEMETERY OR CREMATORY
TRINITY AME ZION CEM DELTA, PENN. | | 23h. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR
NAME
LEROY O. DYETT 4600 LIBERTY HEIGHTS AV | | | | 25. DATE REC'D. BY REGISTRAR
DEC 31 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson</u> | | | | |

10123 00000

156

10123 00000
10123 00000
10123 00000
10123 00000

10123 00000

074683

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO.

34488
315-09-7785

| | | | | | | | | | | | | | |
|---|--|---|--|---|-------------------------|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ELSIE M. CARTER | | | 2a. DATE OF DEATH
MONTH 12 DAY 6 YEAR 87 | | 2b. HOUR
6 PM | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 2 DAY 5 YEAR 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
MD casualty | | | | | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3533 Keswick Rd. 21211 | |
| 14. FATHER'S NAME
FIRST Walter MIDDLE LAST Hulse | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Elsie MIDDLE LAST Carback | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
215-09-7785 | | 17. INFORMANT
ADDRESS
Walter Taylor 3533 Keswick Rd. 21211 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Renal failure
DUE TO, OR AS A CONSEQUENCE OF:
(b) Laryngeal Ca, S/P laryngectomy
DUE TO, OR AS A CONSEQUENCE OF:
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
H. Alajaji | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12.6.87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. H. Alajaji | | | | | | 22e. ADDRESS
Good Samaritan Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Zion Cemetery | | 23d. LOCATION
CITY OR TOWN Freelands, Balto., COUNTY Maryland STATE | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME Burgee-Henss Funeral Home ADDRESS 3631 Falls Road | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC - 9 1987 | | 25b. REGISTRAR'S SIGNATURE
Edith Pender | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

07 APR 1961

20% COTTON FIBER

CHICKEN W. BROWN

187-2-181

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34486

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST Fred MIDDLE Carter LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/7/87 | | 2b. HOUR
M | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12/7/29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4226 Bonner Rd. 21216 | |
| 14. FATHER'S NAME
FIRST Fred MIDDLE Carter LAST | | 15. MOTHER'S MAIDEN NAME
FIRST Susanna MIDDLE Palmer LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
213-28-5706 | 17. INFORMANT ADDRESS
Susanna Hardin 4226 Bonner Rd. 21216 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>renal failure</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/20/87</u> to <u>12/7/87</u> that (I) (we) last saw the deceased alive on <u>11/20/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE
<u>C.D. Kearney MD</u> | | DEGREE | | 22c. DATE SIGNED
<u>12/9/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>CHRISTOPHER D. KEARNEY</u> | | 22e. ADDRESS
<u>700 WASH BVD BALT MD 21230</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/11/87 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westport Md. | |
| 24. FUNERAL DIRECTOR
NAME
Estep Bros. F.H. 1300 Eutaw Pl. | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>J. B. ...</u> | |

072371 000100

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D. C. 20315

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF STAFF
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly discussing military operations or administrative matters. Key words like "TO:", "FROM:", and "SUBJECT:" are visible at the top.]

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34487

FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Robert E. CARTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/26/87 | | 2b. HOUR
MIN.
2:15 P.M. |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
8 14 1922 | 6. AGE (IN YEARS LAST BIRTHDAY)
65 | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore city | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GEN. HOSP. | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
CLERK | 12b. KIND OF BUSINESS OR INDUSTRY
Soc. SEC. ADM. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTO. MD. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BURLEIGH CARTER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY NORRIS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W W II 215-14-5419 | 17. INFORMANT MRS. BALTIMORE, MD. 21217
MARY E. CARTER 1629 N. FULTON AVENUE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis, pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) metastatic carcinoma of colon to lungs & brain
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Rectal Bleeding | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6 19 87 , to 12/26 19 87 , that (I) (we) last saw the deceased alive on 12/26 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Marcos B. Galicia | | DEGREE
MD | | 22c. DATE SIGNED
12/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCOS B. GALICIA MD | | 22e. ADDRESS
North Charles General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/31/1987 | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | |
| 24. NAME OF FUNERAL HOME, INC.
ADDRESS
2501 GWYNNS FALLS PKWY BALTO, MD. 21216 | | DATE REC'D. BY REGISTRAR
DEC 29 1987 | | REGISTRAR'S SIGNATURE
Wanda Hordell | |

076593 DEC 30 1987

RECEIVED

DEC 26 1964

LIBRARY

U.S. DEPT. OF JUSTICE

DEC 26 1964

075158 DEC 16 1987

18, 21abcdef, 22a, Film G635 1/18/88
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4 4 8 8

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|------------------|--|--------------------------|--|-------|--|----------|--|------|--|----------|--|----|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| Sherry | | A. | | | | Carter | | EST. <input checked="" type="checkbox"/> MATED <input type="checkbox"/> | | 12 | | 12 | | 19 | | 87 | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | | |
| F | | B | | 2 27 52 | | 35 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 12 | | 12 | | 19 | | 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| Baltimore | | 131 N. Aisquith St. | | Clerk | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | |
| Maryland | | | | Balto. City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1812 Druid Hill Ave | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | |
| Garvie | | Alice | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | | | |
| NO | | 219-52-7545 | | Linda Paige | | 1005 N. Ellamont St | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a). Narcotic and alcohol intoxication | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | | | (b) | | | | | | | | | | | | | | | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/12/87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| | | | | Subject used drugs and ingested alcohol | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| | | Building | | 131 Aisquith St., Balto., Md. | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE | | | | | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | Deputy Chief | | 12-13-87 | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| Burial | | 12-17-87 | | Cedar Hill Cemetery | | Baltimore Maryland | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| Wm. C. Brown | | 1206 W. North Ave | | DEC 15 1987 | | Julia Davis | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

075125 271270

80% COTTON LBER

WIKI TIT



Handwritten signature or mark

075125 271270

076875 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR Item#17 Film#g653

1- STATE REGISTRAR 07/07/89 DA J-g.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO 34489

| | | | | | |
|---|--|---|--|--|-----------------------------------|
| DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SURETHER CARTER | | 2a DATE OF DEATH
MONTH DAY YEAR
12/24/87 | | 2b HOUR
M
2:42 P | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
06 17 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
71 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MS | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY BALTO 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 6704 LAUREL Dr. 21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Sylvester Martin | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Martin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
345-14-4974 | | 17. ADDRESS
Rubie Carter 6704 Laurel Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULM ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) HEART FAILURE, HEPATIC ENCEPHALOPATHY
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 12/14 87 to 12/24 87 that (1) (we) last saw the deceased alive on 12/24 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Thomas Rosenthal | | DEGREE
M.D. | | 22c. DATE SIGNED
12/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. ROSENTHAL | | 22e. ADDRESS
SINAI HOSPITAL 9427 M.L. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/31/87 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEMORIAL PARK | |
| 23d. LOCATION
CITY OR TOWN
ARBUTUS | | COUNTY
MD | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H, INC. | | ADDRESS
1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1987 | |

075728 DEC 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4490

| | | | | | | | | | | | | | | | | | |
|---|---------|---|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|-----------------------------------|--|------|--|-------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE KNOWN OF DEATH EST. MATED | | MONTH | | DAY | | YEAR | | 7b HOUR | |
| Peter | | Casella | | | | | | X | | 12-13 | | 19 | | 87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| M | W | 10 25 22 | | 65 YRS. | | | | | | 12-13 | | 19 | | 87 | | 10:31 P. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| PENN. | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City, | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | North Charles General Hospital | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD. | | | | BALTIMORE | | YES X NO | | 2303 MARYLAND AVE. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| | | 166-16-1813 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>
OTHER CAUSE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) <u>Fibrinous Pericarditis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES X NO | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Autopsy X Inspection Inquiry and in my opinion | | | | | | | | | | | | | | | |
| Actual Signature | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 12-14-87 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Mario F. Golle, Jr., M.D. | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| Removal | | 12-18-87 | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME | | ADDRESS | | | | | | | | | | | | | | | |
| State Anatomy Board | | Balto., Md. | | | | | | | | | | DEC 21 1987 Julia Davidson-Rudner | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (1))

01301 01301

51814 MOTTOS 2008

DAVID WAREHEAD



74796 DEC 14

Item 16b., G-534, 12/18/87, Per/F.H., and a STATE OF MARYLAND

FOR copy of S.S.Card, / Gbj.
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34491

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Frances Catterton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 9, 1987 | | 2b. HOUR
5:30 PM |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
01/ 09/ 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65
IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE, MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
ARBUTUS | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
1330 BIRCH AVENUE 21227 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN BRITTINGHAM | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NELLIE MAJORS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-18-7070
212 01 9931 | | 17. INFORMANT
ADDRESS
ELMER L. CATTERTON 1330 BIRCH AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>heart cancer in left ventricle, head, liver</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>history of pulmonary edema</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27, 1985, to 12/9, 1985, that (I) (we) last saw the deceased alive on 12/7, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Brenda W. Cooper | | DEGREE
MD | | 22c. DATE SIGNED
12/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Brenda W. Cooper MD | | 22e. ADDRESS
University of MD Carey Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/12/87 | 23c. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DORSEY HOWARD MARYLAND | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1987 | |
| 24. FUNERAL DIRECTOR
NAME
AMBROSE FUNERAL HOME | | ADDRESS
1328 SULPHUR SPRING ROAD | | 25b. REGISTRAR'S SIGNATURE
J. L. Kishner | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

100-100000-100000

077008 JAN 15 1988

REG. NO. 4492

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|--------------------------------------|--|--|---|--|--|-------|--|--|----------|--|--|-------|--|--|-----------|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH | | | DAY | | | YEAR | | | 7b. HOUR | | | | | | | | |
| Roosevelt | | | Causey | | | | | | | | | 12-28-87 | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | | IF UNDER 1 YR. | | | IF UNDER 24 HRS. | | | 7c. DATE PRONOUNCED DEAD | | | MONTH | | | DAY | | | YEAR | | | 2d. HOURS | | |
| Male | | | Black | | | 10 17 38 | | | 49 | | | | | | | | | 12-28- | | | 19 | | | 87 | | | 8:43P | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | NEVER MARRIED | | | DIVORCED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Del. | | | U.S.A. | | | WIDOWED | | | | | | | | | Baltimore City | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | |
| Baltimore | | | University Hospital | | | Laborer | | | Construction | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | | | | |
| Del. | | | | | | Harrington | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | P.O. Box 39 | | | 99999 | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | | | | | | | | | | |
| Wallace | | | Pearl | | | No | | | 222-247060 | | | Sarah Causey | | | Rt. 1 | | | Ayr 57 Del. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | PART I DEATH WAS CAUSED BY: | | | IMMEDIATE CAUSE (a) | | | Multiple injuries | | | | | | | | | | | | | | | | | | | | | | | |
| 8120 | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | (b) | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 10:15AM 12-28-87 | | | | | | Driver in auto/auto collision | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | |
| | | | | | | road | | | | | | Route 404, 1mi. east of Newtwn Road, Easton, Talbot County, MD | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I am in charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | | | | | | | | | | | | | | | | | |
| Charles P. Kokes, M.D. | | | | | | Assistant | | | | | | 12-29-87 | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | | 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION | | | | | | | | | | | | | | |
| Burial | | | | | | Jan 2, 1988 | | | | | | St. James Cem. | | | | | | City or Town | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | |
| Carlton C. Dargatzis | | | | | | 1701 Mc Call St. | | | | | | DEC 30 1987 | | | | | | De laura | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE WITHIN 72 HOURS, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))

HAIR-10000000000000000000

00000000000000000000



074624 DEC 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34493

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Josephine V CAVANAUGH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 7, 1987 | | 2b. HOUR
8:45 P.M. |
| 3. SEX
FEMALE | 4. RACE
CAUCASION | 5. DATE OF BIRTH
MONTH DAY YEAR
3 13 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Pa. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
828 N. Eutaw Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home Maker |
| 13a. STATE
MD. | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lewis Staskiel | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophia Andraychak | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
209-16-4317 | | 17. INFORMANT
ADDRESS
Sharon Banks 236 Paradise Road Aberdeen Md 21001 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Metastases Bone & Mediastinum + Lung.
(c) Carcinoma of Breast. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
2 m.
4 m. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that it (this hospital) attended the deceased from 12-2 , 19 87 , to 12-7 , 19 87 , that it (we) last saw the deceased alive on 12-7 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert C. Irwin M.D. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-8-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert C. Irwin M.D. | | 22e. ADDRESS
828 N. Eutaw St. Balto Md 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
12/10/87 | 23c. NAME OF CEMETERY OR CREMATORY
St Michaels Cemetery | | 23d. LOCATION
Glen Lyon Luzerne Pa. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
George J. Gonce 4001 Ritchie Hwy Balto Md | | | 25a. DATE REC'D. BY REGISTRAR
DEC - 9 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Julia Smith-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

1001 331 135 A 7

075153 DEC 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
REGINA C CAVANAUGH | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 87 | | | | | 2b. HOUR
2343 M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 22, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS | | 7b. IF UNDER 24 HRS
HOURS MIN.
2343 M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
State of Md. | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
407 E. Coldspring Lane 21212 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James A. Cavanaugh | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Catherine Mansfield | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(# YES, GIVE WAR OR DATES)
213-26-6255 | | 17. INFORMANT
ADDRESS
907 Sibley Rd.
Patricia C. Ernest Towson, Md. 21204 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Attack | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
45 min. | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arrhythmia | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Abnormal Shunt for Syringomyelia | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/4/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Congenital Syringomyelia. Hydrocephalus | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12/87 to 12/12/87 , that (I) (we) last saw the deceased alive on 12/12/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
K. Eaton | | | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/13/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
K. Eaton M.D. | | | | | 22e. ADDRESS
201 University Parkway
Union Memorial Hosp. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
December 14, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Maryland | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home, Inc. Balto., Md 21212 | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 15 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

074227 DEC-78

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34495

| | | | | | | | | |
|--|--|--|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
CLARENCE EDWIN CAVEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 2 87 | | | 2b. HOUR
5:45 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9/6/05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician-Westinghouse | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Cornelius Cavey | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lula Ellis | | | 13e. STREET ADDRESS
Balto., Md. 21207
5907 Queen Anne St. #07 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-03-6183 | | 17. INFORMANT
3581 Folly Quarter Rd. #21043
Mrs. Frederick Muhl-Ellicott City Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGENITIVE HEART FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARDIOMYOPATHY</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>VALVULAR HEART DISEASE</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 30</u> , 19 <u>87</u> , to <u>DEC 2</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>DEC 2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
 | | | | DEGREE
RESIDENT | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BOON P. LIM, MD | | | | 22e. ADDRESS
ST AGNES HOSPITAL
900 CATON AVE, BALTIMORE, MD 21229 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 5, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ellicott City, Md. | | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab | | | | 5151 Balto. Nat'l. Pike
#21229 | | 25a. DATE REC'D. BY REGISTRAR
DEC 03 1987 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages read 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

100-100-100-100

076567 DEC 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4496

| | | | | | | | | | | |
|---|---------|--|--------|---|-------------------------|---|-------|------------------------------------|------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Nicholas Chagouris | | | | | 2a. DATE KNOWN OF DEATH | | 12 | 24 | 1987 | 7:45 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | 7. DATE | | MONTH | | DAY | YEAR |
| Male | White | 2 2 20 | | 67 YRS. | 7. DATE | | 12 | | 24 | 1987 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Baltimore City | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Mercy Hospital | | | | Owner | | Retail Seafood | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Maryland | | Baltimore | | Timonium | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2127 Pot Spring Road | | 21093 |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Louis Chagouris | | | | Stella Matthews | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| Yes | | WW II | | 213-18-0449 | | Mrs. Jean V. Chagouris | | 2127 Pot Spring Rd., Timonium, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Aortic valvular disease</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | |
| Mario F. Golle, Jr. M.D. | | Assistant MEDICAL EXAMINER | | | | 12/25/87 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | BALTO., MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 12-28-87 | | Parkwood Cemetery | | Baltimore Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Ann S. Matthews, Matthews Funeral Home
3021 Eastern Ave., Baltimore, Md. 21224 | | | | | | DEC 29 1987 | | John Davidson-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 37. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MA

BP

DHMH - 17
(VR A15 ME (5))

07600 10000

State of Ohio

x

County of Hamilton

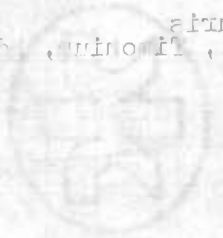
State of Ohio

County of Hamilton

Know all men by these presents, that I, the undersigned, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Hamilton, State of Ohio.

Witness my hand and seal of office this 10th day of March, 1906.

Notary Public for the State of Ohio
My Commission Expires March 10, 1907



Notary Public for the State of Ohio

My Commission Expires March 10, 1907

076608 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34497

| | | | | | |
|---|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) PATRICIA CHAMPAINY | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 29 87 | | 2b. HOUR
9:4 M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8 27 42 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
45 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Middle River | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Feehley | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Doris Riser | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
214-40-0612 | | 17. INFORMANT
ADDRESS
Jeanine Champainy 4000 Rustico Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) 30 DAYS
DUE TO, OR AS A CONSEQUENCE OF:
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: STRESS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
William Feehley MD | | DEGREE | | 22c. DATE SIGNED
12-29-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William Feehley | | 22e. ADDRESS
FRANCIS SCOTT KEY HOSP | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/31/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 23e. DATE REC'D BY REGISTRAR
DEC 30 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Connelly Funeral Home 300 Mace Ave. 21221 | | 25. REGISTRAR'S SIGNATURE
Jeanine Champainy | | | |

BP

070-00-10-21-27

h

078226 JAN 13 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

MEDICAL CERTIFICATION

Item 13 per phone A.B. 1/13/88 DAD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34498

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HAZE C | | | 20. DATE OF DEATH
MONTH DAY YEAR
12/29/87 | | | 2b. HOUR
9.30 PM | | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
3 6 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BMT CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Med Cntr | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2803 Garrison Blvd. 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | |
| 16b. SOCIAL SECURITY NO.
213-62-2499 | | 17. INFORMANT ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Advanced Resp. disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Advanced Neurological Disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10/87 19 to 12/29 19 87, that (I) (we) lost saw the deceased alive on 12/28/87 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
M. MacDonald | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/29/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MACDONALD | | 22e. ADDRESS
9141 BROTHERMAN AVE E C MD 21043 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
1-2-88 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1988 | | 25b. REGISTRAR'S SIGNATURE
Julia Dendron-Randall | | |

FOX CLOTH LINE

EXP. 10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

075756 DEC 22 87

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34499

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST <i>Lillian</i> MIDDLE LAST <i>Chapman</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 17 87</i> | | 2b. HOUR
<i>7:10 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>02 11 33</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY))
YRS. MONTHS DAYS
<i>54</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Medical Ctr</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>NA</i> | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>BALTO.</i> | | 13c. CITY OR TOWN
<i>BALTO.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George Dickenson</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Myrtle Wilson</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>217-24-2905</i> | |
| 17. INFORMANT
<i>Joseph Chapman</i> | | ADDRESS
<i>1135 W. Mont Court 21202</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Asystole (Cardiac Arrest)</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Mitchell Steiner</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Mitchell Steiner MD</i> | | 22e. ADDRESS
<i>FSK</i> | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>12/22/87</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>GARRISON FOREST VET CEMETERY</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>OWINGS MILLS, MD</i> | | 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 21 1987</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>John...</i> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

72128 DEC 25 97

RECEIVED
JAN 12 1898
LIBRARY

DEC 25 1897

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34500

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

O'Donnell

J.

CHAPPELL

2a. DATE OF DEATH MONTH DAY YEAR
December 29, 1987

2b. HOUR

7:43A M

3. SEX

MALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH DAY YEAR
1 17 1920

6. AGE (IN YEARS LAST BIRTHDAY)

67 YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
TRUCK DRIVER

12b. KIND OF BUSINESS OR INDUSTRY

ZAMOISKI Co.,

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

BALTO, MD, 963 ELLICOTT DR. WAY 21216

14. FATHER'S NAME

FIRST
GEORGE

MIDDLE

LAST
E. CHAPPELL

15. MOTHER'S MAIDEN NAME

FIRST
IDA

MIDDLE

LAST
BELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

WWII

17. INFORMANT

MRS. MARION SCHENCK

ADDRESS

BALTO, MD, 963 ELLICOTT DR. 21216

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Grand Mal Seizure

DUE TO, OR AS A CONSEQUENCE OF

(b) Anoxic brain damage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(c) Carcinoma of the lungs with metastases

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 days

years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Hypotension (refractory) Status Post cardiopulmonary arrest 12/25/87

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (y) (this hospital) attended the deceased from December 25, 1987, to December 29, 1987, that (x) (we) lost

saw the deceased alive on December 29, 1987, and that in (y) (our) opinion death occurred on the date and hour and from the causes stated

above, (y) (we) (did) (not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/29/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

M. ZUGHAYR MD

22e. ADDRESS

c/o Maryland General Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

11/04/1988

23c. NAME OF CEMETERY OR CREMATORY

BALTO. NATIONAL CEM.

23d. LOCATION

BALTIMORE, MD.

COUNTY

STATE

24. FUNERAL HOME OR OTHER INSTITUTION

NAME ADDRESS
2501 GWYNNS FALLS PKWY. BALTO. MD. 21216

25a. DATE REC'D. BY REGISTRAR

JAN 7 1988

25b. REGISTRAR'S SIGNATURE

Sander Rudack

133

2

BLACK 1 17 1150

MADE IN U.S.A.

WATER PROOF
BATTERY X

GEORGE E. CHAPMAN
YES



WATER PROOF
BATTERY X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

Items 7a, 14, 15, Film G634 sb

FOR 12-11-87 funeral home

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34501 REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GOLDIE Helen CHASE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-08-87 | | | 2b. HOUR
1:15 A | |
| 3. SEX
F | | 4. RACE
B V | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 26 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NA MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Glen UNKNOWN Morgan | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Goldie UNKNOWN Wade Matthews | | 13e. STREET ADDRESS / ZIP CODE
2849 Woodbrook Ave 21217 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-16-4290 | | 17. INFORMANT ADDRESS
Henrietta Mosley 2854 Woodbrook Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SHOCK, CARADIOGENIC
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) PROBABLE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c) ANEMIA 2° GI BLEEDING | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
LIVER DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/7 , 19 87 , to 12/8 , 19 87 , that (I) (we) last saw the deceased alive on 12/8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
BICH T DUNG | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BICH T DUNG | | 22e. ADDRESS
LIBERTY MEDICAL CENTER | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CATONSVILLE, MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

19

2

RECEIVED

5011300 11 11 1950

RECEIVED

RECEIVED

RECEIVED

077161 JAN 5 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

34502
REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|--|--|--|---|--|---|--|---------------------|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Andre | | MIDDLE | | LAST
Chatman | | 2a. DATE KNOWN OF DEATH | | MONTH
12/ | | DAY
31/ | | YEAR
87 | | 2b. HOUR
3:58 P.M. | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 25 73 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
14 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12/ 31/ 87 | | 10. HOUR
3:58 P.M. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | | | | | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
BALTIMORE | | | | 13d. INSURE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
413 E. LANVALE STREET 21202 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES CHATMAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LONZENA QUICKLEY | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES
NO | | | | 16b. SOCIAL SECURITY NO.
220-84-1447 | | | | 17. INFORMANT
LONZENA QUICKLEY | | | | ADDRESS
413 E. LANVALE STREET | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hanging
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR XX MONTH DAY YEAR
P.M. 12/31/ 19 87 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject found hanged | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home (steps) | | | | 21f. LOCATION
CITY OR TOWN COUNTY STATE
413 E. Lanvale St., Balto. City, Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
1/1/88 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
1/5/88 | | | | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW CEMETERY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DUNDALK, MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H. INC. | | | | ADDRESS
1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4-1988 | | | | 25b. REGISTRAR'S SIGNATURE
John L. ... | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN SPACE IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

075101-260

30% COTTON FIBER

WINTER DMD



075626 DEC 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34503
REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dorilla Henriette Chevalier | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 17 87 | | 2b. HOUR
6:15 AM |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
10 05 15 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Vermont | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Caton Manor Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Assembler | | 12b. KIND OF BUSINESS OR INDUSTRY
Manufact. |
| 13a. STATE
MD | | | 13b. COUNTY
Carroll | 13c. CITY OR TOWN
Mt. Airy | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest O. Simard | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amedee Dube | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Raymond P. Chevalier Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ANOXIC BRAIN DAMAGE 2°</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC ARREST 9/20/87</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>WITH 2° SUPPUR</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>CHRONIC ATRIAL FIBRILLATION, ANEMIA, FOLEY CATHETER</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) this hospital attended the deceased from <u>11/23/87</u> to <u>DEATH</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12/2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Albin O. Kuhn II</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>12/17/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Albin O. Kuhn, M. D. | | 22e. ADDRESS
1001 Pine Heights Ave. 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | 23e. DATE REC'D. BY REGISTRAR
DEC 18 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
Cremation Society of MD, Baltimore, MD | | 25. REGISTRAR'S SIGNATURE
<u>John B. ...</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

1515:00-02227

1515:00-02227

1515:00-02227

1515:00-02227

1515:00-02227

074213 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34504
REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MELVIN H. CHISHOLM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 1 87 | | | 2b. HOUR
12:50 PM | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5/20/51 | | 6. AGE (IN YEARS LAST BIRTHDAY)
36 YRS. | | 7a. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carrier | | 12b. KIND OF BUSINESS OR INDUSTRY
City Express Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
650 Cokebury Ave. 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nathaniel Chisholm | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Johnnie Mae Chisholm | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-52-8532 | | 17. INFORMANT
ADDRESS
Linda Chisholm 650 Cokesbury Ave. 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>MULTIPLE ELECTROLYTE ABNORMALITIES</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>RENAL FAILURE, DKA</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>POSSIBLE THYROID DISEASE</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> 19 <u>87</u> , to <u>12/1</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/1</u> 19 <u>87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | | DEGREE | | 22c. DATE SIGNED
<u>12/1/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LLEWELLYN KITCHIN, M.D. | | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE IF V)
Burial | | | 23b. DATE
12/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Estep Bros. F.H. 1300 Eutaw Place | | | | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>DEC 04 1987</u> <u>[Signature]</u> | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

074518 DEC 70

20% COTTON LIBER

WOLF MARK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 4 5 0 5

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CONSTANTINE D. CHRISIKOS | | | 2a. DATE OF DEATH
MONTH 12 DAY 4 YEAR 87 | | | 2b. HOUR
2⁴⁵ P.M. | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 5 DAY 7 YEAR 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND, US. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GEN HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MECHANIC | | 12b. KIND OF BUSINESS OR INDUSTRY
A.J. Venting | | | | |
| 13a. STATE
M.O. | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
910 WANDER RD LINTHICUM 21090 MD | |
| 14. FATHER'S NAME
FIRST UNKNOWN MIDDLE NICOLAS LAST CHRISIKOS | | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN MIDDLE MARK LAST KRIS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) UNKNOWN | | | 16b. SOCIAL SECURITY NO.
229-14-4980 | | | 17. INFORMANT
John Helen Chrisikos, 8250 Lethbridge Rd. Millersville, Md. 21108 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-PULMONARY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) END STAGE LUNGER FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) ALCOHOL ABUSE | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 MONTHS
30 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
CONGESTIVE HEART FAILURE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/18 19 87 to 12/4 19 87 that (I) (we) last saw the deceased alive on 12/4/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Carlos Lopez | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/4/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CARLOS LOPEZ | | | | | | 22e. ADDRESS
3001 HANOVER ST BAL MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
12/6/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process Inc. Catonsville, Md. Balto. Co. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Balto. Md. 21230
McCully Funeral Home, 130 E. Fort Ave. | | | | | | 25. DATE REC'D. BY REGISTRAR
DEC - 7 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

BP

074300 DEC-30-61

DEC-30-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 076369 DEC 28 1987
FOR STATE REGISTRAR
1- DECEASED NAME FIRST MIDDLE LAST
Albert C. Christopher | | | | | | | | | |
| 2a DATE OF DEATH MONTH DAY YEAR | | 2b HOUR | | | | | | | |
| 12 25 87 | | 7:10 P.M. | | | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| MALE | | WHITE | | 2 23 13 | | 74 | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD | | USA | | | | CITY of Baltimore MD | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | South Balt. Gen. Hosp | | | | SUPERVISOR | | U.S. GOV'T. | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE | |
| MD | | ANNE ARUNDEL | | PASADENA | | YES | | 778 Holly Ave / 21122 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Albert J. Christopher | | MARY C. SAUNDERS | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| NO | | 215 03 1028 | | Alice M. Christopher | | 718 Holly Ave. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Squamous cell lung carcinoma with metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>12-23</u> , 19 <u>87</u> , to <u>12-25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | DEGREE | | | | 22c DATE SIGNED | |
| B. Pimentel | | | | MD | | | | 12-25-87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | | | |
| B. Pimentel MD | | | | South Balt. Gen. Hospital | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIAL) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY | | | |
| CREMATION | | 12/26/87 | | Westview Park | | Catonsville Balto. Md | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Raymond C. Fink Glen Burnie, Md. 21061 | | | | DEC 28 1987 | | Julia Barker-Powell | | | |

BP

077169 JAN - 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4507

| | | | | | | | | | | | | | | | | | |
|---|--------|--|--|---|--|---|--|-----------------------------------|--|--|--|-------------------------------------|--|-------------------|--|-------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b HOUR | |
| Anthony | | Cichocki | | | | | | 12/18/87 | | 12 | | 18 | | 87 | | 9:27 a.m. | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| M | W | 3 17 26 | | 61 YRS | | | | | | 12/18/87 | | 12 | | 18 | | 87 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD. | | U.S.A. | | | | | | | | | | Baltimore City, | | | | MD | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 404 S. Wolfe St. | | DISABLED VET. | | PENSION | | | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | | | | | | | |
| MD. | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 404 S. WOLFE ST. | | | | | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| ANTHONY CICHOCKI SR. | | MICHALINA HELEN KRUGER | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | | | | | | | |
| YES | | 216-20-4100 | | V.H. Records | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19 CAUSE OF DEATH | | 20 CAUSE OF DEATH | | 21 CAUSE OF DEATH | | 22 CAUSE OF DEATH | | 23 CAUSE OF DEATH | | 24 CAUSE OF DEATH | | 25 CAUSE OF DEATH | | 26 CAUSE OF DEATH | |
| Chronic Obstructive Pulmonary | | Disease and Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f LOCATION | | | | | | | | | | | | | |
| | | | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> | | Inspection <input checked="" type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion | | | | | | | | | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | Assistant | | 12/18/87 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | | | | | | | | | | |
| Burial | | 1/17/88 | | Arlington National Cemetery | | Ft. Myer, Virginia | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | ADDRESS | | DATE REC'D. BY REGISTRAR | | REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Eric Connel | | 1712 W. North Ave. | | JAN 5 1988 | | John D. D. D. | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

POST OFFICE BOX

1000

THREE IN A ROW



THREE IN A ROW

THREE IN A ROW

074946 DEC 15 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34508

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Constance
CONSTANCE | | MIDDLE
Blanche | | LAST
CIESIELSKI
CIESIELSKI | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 87 | | 2b. HOUR
7:35 P | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 4 89 | | 6. AGE (IN YEARS LAST BIRTHDAY)
98 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Housework | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
516 S. Newkirk St. 21224 | |
| 14. FATHER'S NAME
Adam | | MIDDLE
Sobolewski | | LAST
Anna | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Viola Gpeller | | ADDRESS
2418 Harwood Rd. 21224 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-74-4908 | | 17. INFORMANT
Viola Gpeller | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Aspiration of pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Colon cancer, senile dementia, atrial fibrillation</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> , 19 <u>87</u> , to <u>12/12</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12/12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
about (I) (we) (and) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dorian S St Martin | | 22e. ADDRESS
Mercy Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-16-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Saint Stanislaus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. | | ADDRESS
6224 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71



12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

12-11-71

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified apace.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34509

1. FOR
STATE
REGISTER2. DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
Dominic Albert Cirri2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR
12 04 87 5:43 AM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
10 05 18

6. AGE (IN YEARS LAST BIRTHDAY)

69

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Francis Scott Key Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS OR INDUSTRY

City of Balto.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

1024 South Highland Ave. 21224

14. FATHER'S NAME

FIRST MIDDLE LAST
Cologero

MIDDLE

LAST
Cirri

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Gatana

MIDDLE

LAST
Ceranilo

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
Yes(IF YES, GIVE WAR DATES)
W.W. 2

16b. SOCIAL SECURITY NO.

214-16-9327

17. INFORMANT

ADDRESS

Josephine M. Cirri 1024 S. Highland Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 min

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

Cardiac dysrhythmia

45 min

DUE TO, OR AS A CONSEQUENCE OF

(c)

myocardial infarction

2-3 hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/3 19 87 to 12/4 19 87, that (I) (we) last saw the deceased alive on 12/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

H. Jeffrey Schwartz

DEGREE

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☒

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

H. Jeffrey Schwartz

22e. ADDRESS

Francis Scott Key
4940 Eastern Ave. Balt, Md. 2122423a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12-07-87

23c. NAME OF CEMETERY OR CREMATORY

Sacred Heart of Jesus

23d. LOCATION

Dundalk

Balto. Co., Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Charles S. Zeiler & Son Inc. 901 S. Conkling St

ADDRESS

25a. DATE RECEIVED BY REGISTRATION 25b. REGISTRAR'S SIGNATURE
DEC 7 1987 John Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34510

075715 DEC 22 1987

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DORIS Hilton CLARK | | | 20. DATE OF DEATH
MONTH DAY YEAR
12 18 87 | | | 2b. HOUR
11:15 A.M. | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
07 17 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.J. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Westminster | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willard H. Brown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Irene L. Ross | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
088-07-6086 | | 17. INFORMANT ADDRESS
Ramond A. Clark, Same as 13e | | | |

MEDICAL CERTIFICATION

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory arrest. | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Richter's Syndrome | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Seizure. | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

Renal insufficiency. Peritonitis.

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-3-87, 19, to 12-18, 19 87, that (I) (we) lost
saw the deceased alive on 12-18, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Sumner | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUN MI PARK | 22e. ADDRESS
UMCC
22nd S. Greene St. Baltimore, MD. 21201 | | |

| | | | |
|---|-----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-21-87 | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen | 23d. LOCATION
CITY OR TOWN COUNTY STATE
North Brunswick, N.J. |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd., Balto. | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1987 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

012715-17210

THE JOURNAL OF THE

AMERICAN MEDICAL ASSOCIATION

PUBLISHED WEEKLY

CHICAGO, ILL., U.S.A.

Volume 10

Number 1

January 1917

Page 1

100

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

075530 DEC 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34511

| | | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Rev. Ernest Percy Clark, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 14, 1987 | | | 2b. HOUR
M | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 22 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Saint Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Minister | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. Conf. | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5 Cargil Ave. Catonsville, Md. 21228 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Milton Clark | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Session | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No. | | | | 16b. SOCIAL SECURITY NO.
233-38-3860 | |
| 17. INFORMANT
Lantha R. Clark | | | ADDRESS
Maryland 21228 | | | 5 Cargil Ave. Catonsville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>HYPERTENSION</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>COPD</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>August 1971</u> to <u>November 1987</u> , that (I) (we) last saw the deceased alive on <u>November 20, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jesse T. Holmes</u> | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jesse T. Holmes M.D. | | | | | | 22e. ADDRESS
2300 CARRISON BLVD., BALTO, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/19/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Crest Lawn Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Howard, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

Charles Van der Bilt

Highway Division

C-10

100-100101

075758 DEC 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS CERTIFICATE IS VALID FOR 10 DAYS. IF THE DEATH IS NOT REPORTED TO THE MEDICAL EXAMINER WITHIN 10 DAYS, THE MEDICAL EXAMINER SHALL BE RESPONSIBLE FOR THE DEATH. IF THE DEATH IS NOT REPORTED TO THE MEDICAL EXAMINER WITHIN 10 DAYS, THE MEDICAL EXAMINER SHALL BE RESPONSIBLE FOR THE DEATH. IF THE DEATH IS NOT REPORTED TO THE MEDICAL EXAMINER WITHIN 10 DAYS, THE MEDICAL EXAMINER SHALL BE RESPONSIBLE FOR THE DEATH.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4512

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ESTELLE

M.

CLARK

3 SEX

4 RACE

5. DATE OF BIRTH

MONTH

DAY

YEAR

6. AGE (IN YEARS)

(LAST BIRTHDAY)

MONTHS

DAYS

HOURS

MIN.

IF UNDER 1 YR.

IF UNDER 24 HRS.

7a. DATE KNOWN
OF DEATH

X

MONTH

DAY

YEAR

2b HOUR

M

7c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

2d HOUR

M

FEMALE BLACK

7

31

26

61

YRS.

MONTHS

DAYS

HOURS

MIN.

7c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

2d HOUR

M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

TENN.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

146 S. Willard

12a. USUAL OCCUPATION (TYPE OF WORK)

FOR MOST OF WORKING LIFE)

HOUSEWIFE

12b. KIND OF BUSINESS

OR INDUSTRY

N/A

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

146 S. WILLARD STREET

14. FATHER'S NAME

CHARLIE

MIDDLE

ALEXANDER

15. MOTHER'S MAIDEN NAME

DICIA

MIDDLE

NEWTON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

410-22-1524

17. INFORMANT

ADDRESS

FRANK CLARK 146 S. WILLARD STREET

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,

STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

Margarita A. Korell

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 12-17-87

EXAMINER'S NAME
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

BURIAL

23b. DATE

12-22-87

23c. NAME OF CEMETERY OR CREMATORY

ARBUTUS MEM. PK.

23d. LOCATION

ARBUTUS

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

NAME

ADDRESS

WM. C. MARCH F/H 1101 E. NORTH AVENUE

25a. DATE REC'D. BY REGISTRAR

DEC 21 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

1055370 22 570

AMERICAN
WATERWAYS



1055370 22 570

074228 DEC-78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34513
REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(Type in print)
FRANK H. CLARK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 3 87 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
5 4 25 | 6. AGE (in years (last birthday))
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(Country)
TEXAS | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(If not in such facility, give street address)
1200 NORTH CURLEY STREET | | 12a. USUAL OCCUPATION
(Type of work for most of working life)
ATHENS CLEANERS/ RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
(Type in print)
FRANK H. CLARK | | | 15. MOTHER'S MAIDEN NAME
(Type in print)
BLANCHE JOHNSON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes, give war or dates)
NO | | 16b. SOCIAL SECURITY NO.
465-18-4121 | 17. INFORMANT
ADDRESS
DOROTHY CLARK 1200 CURLEY STREET | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Isolated leg & knee</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
b)
DUE TO, OR AS A CONSEQUENCE OF
c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 week</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(At home, street, factory, office, farm, etc.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/11</i> , 19 <i>87</i> , to <i>12/17</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>12/11</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>W. March</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/21/87</i> | |
| 22d. PHYSICIAN'S NAME (Type in print)
MILTON R. MARCH | | 22e. ADDRESS
12100 L 4940 Eastern Ave, BALTIMORE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
12-7-87 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY
BALTIMORE MD |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H, INC. | | ADDRESS
1101 E. NORTH AVENUE | | 25. DATE REC'D BY REGISTRAR
DEC - 4 1987 | |
| | | | | 26. REGISTRAR'S SIGNATURE
<i>Julia Johnson</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

100-100-100-100



075516 DEC 21 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF - MEDICAL EXAMINER ALONG WITH FORM 100.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 5 1 4

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|---|--|-------------------|--|--|--|---------------------|--|---|--|-------|--|--|--|------|--|-------------|--|--|--|----------------|--|--|--|
| 1. FOR STATE REGISTRAR
DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | | | | | |
| Michael | | D. | | | | Clark | | 12-15-87 | | 12 | | 15 | | 87 | | 3:35A | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| male | | black | | 8 2 1960 | | 27 YRS | | | | | | 12-15-87 | | 12 | | 15 | | 87 | | 3:35A | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | |
| Md | | | | U S A | | | | | | | | Baltimore City | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | | | Sinai Hospital | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Md | | | | | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 3020 Oakford Avenue 21215 | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 17. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | | | | | |
| Paul | | | | Whetstone | | | | Marie | | | | Clark | | | | No | | | | 215-74-4239 | | | | Marie Hairston | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | PART 1 DEATH WAS CAUSED BY: | | | | IMMEDIATE CAUSE (a) | | | | DUO TO, OR AS A CONSEQUENCE OF | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| | | | | | | | | Guishot wound of head | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | (b) | | | | DUO TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| | | | | 9:00PM 12-14-87 | | | | Subject shot | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | CITY OR TOWN | | | | COUNTY | | | | STATE | | | | | | | |
| | | | | street | | | | 3300 block West Belvedere Avenue | | | | Baltimore | | | | City, Maryland | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| Charles P. Kokes, M.D. | | | | Assistant | | | | 12-15-87 | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | |
| Charles P. Kokes, M.D. | | | | 111 Penn Street, Baltimore, Md 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | COUNTY | | | | STATE | | | | | | | |
| Burial | | | | 12/18/87 | | | | Cedar Hill Cemetery | | | | Anne Arundel | | | | Co | | | | Md | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Wm. c. March F/H West 4300 Wabash Avenue | | | | DEC 18 1987 | | | | | | | | | | | | | | | | | | | | | | | |

07-84
25M

BP
DHMH - 17
(VR A15 ME (3))

NO 10 1950 1 2 34 0

33611100100 20%

DMC

MA

1111

1111



76565 DEC 30 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 7 3 4 5 1 5

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
NOLAN | | | FIRST MIDDLE LAST
CLARK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26, 1987 | | | 2b. HOUR
7:50 P M | | |
| 3. SEX
Male | | | 4. RACE
Black | | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 2 11 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Balto. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gus Clark | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leslie Brown | | | 16. SOCIAL SECURITY NO.
215-03-5781 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES
No | | | 16b. SOCIAL SECURITY NO.
215-03-5781 | | | 17. INFORMANT
Marie Clark | | | ADDRESS
2105 Bryant Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>UREMIA</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Longstanding heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 hrs</u>
<u>one week</u>
<u>1 year</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Chronic Renal Failure - Abdominal Distension</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>87</u> , to <u>12/26</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12/26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>B. Schlafstein</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<u>2/26/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>B. Schlafstein</u> | | | | | | 22e. ADDRESS
<u>Johns Hopkins Hosp. Balt Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/31/87 | | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C. March F/H West | | | | | | ADDRESS
4300 Wabash Ave. | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | |

MEDICAL CERTIFICATION

1
2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1901 33

1901 33

DEC 9 1901

077124 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. 4516

| | | | | | | | | | | | | | | | | | | | |
|---|--|----------------------------------|--|--|--|-------------------|--|--|--|---|--|----------------------------------|--|-----------|--|---------------------------------------|--|-----------|--|
| 1- STATE REGISTRAR | | 2- DECEASED NAME (TYPE OR PRINT) | | 3- FIRST | | 4- MIDDLE | | 5- LAST | | 6- DATE KNOWN OF DEATH | | 7- MONTH | | 8- DAY | | 9- YEAR | | 10- HOUR | |
| | | Frank | | S. | | Clay | | | | 12-27 | | 19 | | 87 | | | | | |
| 3- SEX | | 4- RACE | | 5- DATE OF BIRTH | | 6- AGE (IN YEARS) | | 7- IF UNDER 1 YR. | | 8- IF UNDER 24 HRS. | | 9- DATE PRONOUNCED DEAD | | 10- MONTH | | 11- DAY | | 12- YEAR | |
| Male | | Cau. | | Apr. 28, 1912 | | 75 YRS. | | | | | | 12-27 | | 19 | | 87 | | 3:38 P.M. | |
| 13- BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 14- CITIZEN OF WHAT COUNTRY? | | | | 15- MARRIED | | | | 16- NEVER MARRIED | | | | 17- BALTIMORE CITY OR COUNTY OF DEATH | | | |
| West Virginia | | | | U.S.A. | | | | WIDOWED | | | | DIVORCED | | | | Baltimore City, MD | | | |
| 18- CITY OR TOWN OF DEATH | | | | 19- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 20- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 21- KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | | | St. Agnes Hospital | | | | Miner | | | | Coal | | | | | | | |
| 22- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | |
| 23a- STATE | | | | 23b- COUNTY | | | | 23c- CITY OR TOWN | | | | 23d- INSIDE CITY LIMITS? | | | | 23e- STREET ADDRESS | | | |
| Maryland | | | | N/A | | | | Baltimore | | | | YES | | | | 2914 Benson Ave. 21223 | | | |
| 24- FATHER'S NAME | | | | | | | | | | 25- MOTHER'S MAIDEN NAME | | | | | | | | | |
| Lewis | | | | | | | | | | Rurie | | | | | | | | | |
| 16a- WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b- SOCIAL SECURITY NO. | | | | | | | | | |
| No | | | | | | | | | | 236-10-2215 | | | | | | | | | |
| 17- INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | |
| Joyce Blackwell | | | | | | | | | | 638 Mountain Ave., SE Roanoke, VA 24013 | | | | | | | | | |
| 18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease and | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Aortic Stenosis | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Pulmonary Disease | | | | | | | | | | | | | | | | | | | |
| 19a- DATE OF OPERATION | | | | | | | | | | 19b- CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | |
| 20a- EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | | | | | | | 20b- TIME OF INJURY | | | | | | | | | |
| 20c- INJURY OCCURRED WHILE AT WORK | | | | | | | | | | 20d- PLACE OF INJURY | | | | | | | | | |
| 20e- HOW INJURY OCCURRED | | | | | | | | | | 20f- LOCATION | | | | | | | | | |
| 20g- I certify that I took charge of the remains described above, held an autopsy | | | | | | | | | | 20h- INSPECTION | | | | | | | | | |
| 20i- INQUIRY | | | | | | | | | | 20j- AND IN MY OPINION | | | | | | | | | |
| 20k- DEATH RESULTED FROM | | | | | | | | | | 20l- TITLE (SPECIFY) | | | | | | | | | |
| 20m- ACTUAL SIGNATURE | | | | | | | | | | 20n- DATE SIGNED | | | | | | | | | |
| 20o- EXAMINER'S NAME | | | | | | | | | | 20p- ADDRESS | | | | | | | | | |
| 20q- BURIAL, CREMATION, REMOVAL | | | | | | | | | | 20r- DATE | | | | | | | | | |
| 20s- NAME | | | | | | | | | | 20t- ADDRESS | | | | | | | | | |
| 20u- DATE REC'D. BY REGISTRAR | | | | | | | | | | 20v- REGISTRAR'S SIGNATURE | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

| | | | | | | | | | | | |
|---|--|-----------|--|------------------------------------|--|-------------------------------|--|----------------------------|--|------------|--|
| 23a- BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b- DATE | | 23c- NAME OF CEMETERY OR CREMATORY | | 23d- LOCATION (CITY OR TOWN) | | 23e- COUNTY | | 23f- STATE | |
| Burial | | 30 Dec 87 | | Spruce Grove Cemetery | | Basin, West Virginia | | | | | |
| 24- FUNERAL DIRECTOR NAME | | | | | | 25a- DATE REC'D. BY REGISTRAR | | 25b- REGISTRAR'S SIGNATURE | | | |
| Capitol Funeral Service, Falls Church, VA | | | | | | JAN 4 1988 | | | | | |

077124-21-240

8.

State: New Virginia
Date: Apr. 28, 1912
U.C.A.

2014 Belmont Ave.
21227

2127
220-10-2212
(Don't forget)
Don't forget to
don't forget to



200% 100%

Don't forget to
Don't forget to
Don't forget to
Don't forget to

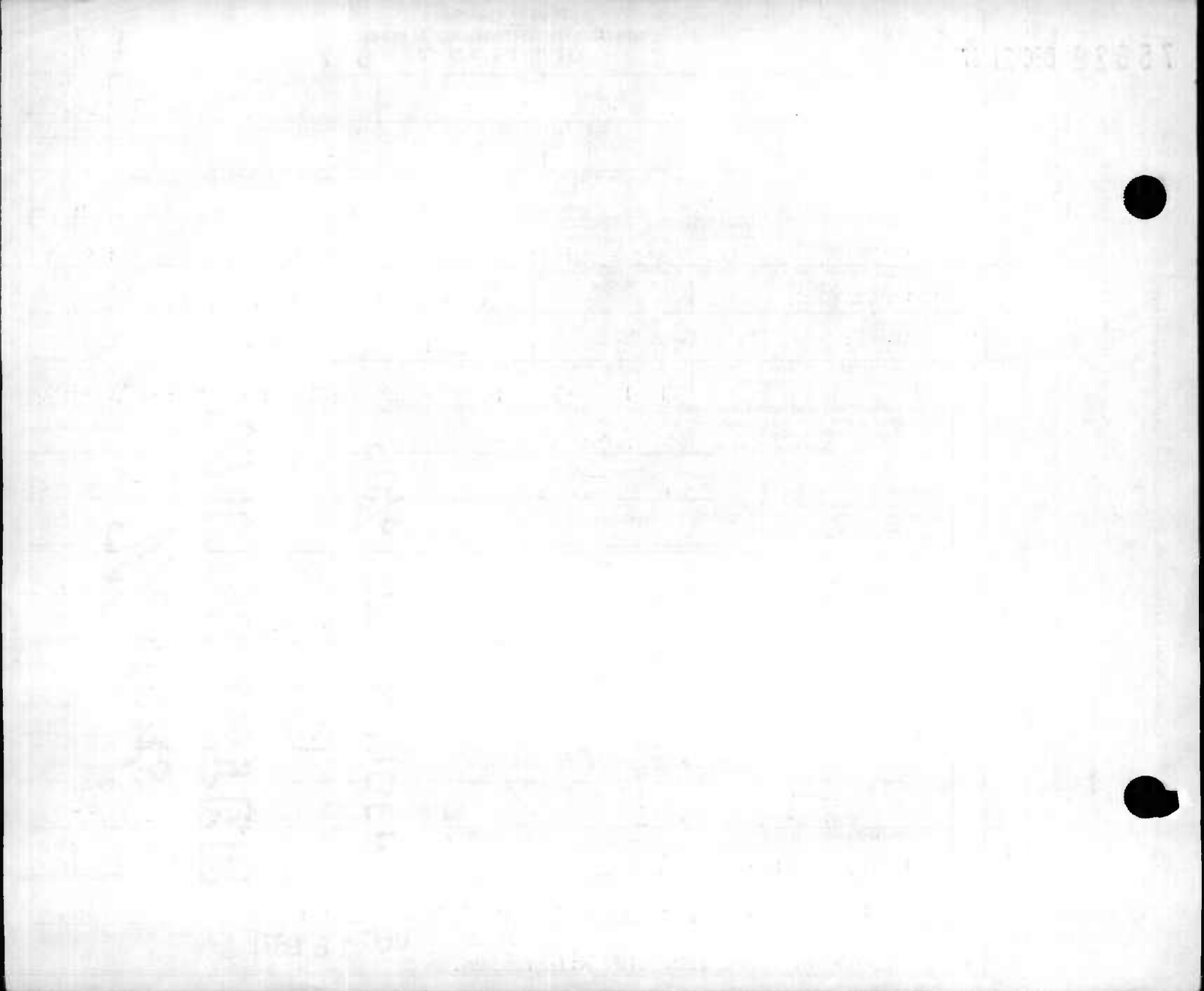
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 5 1 7
REG. NO.FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY ELIZABETH CLEMENTS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 87 | | 2b. HOUR
3:05 P.M. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
11 17 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Telephone Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
RailRoad |
| 13a. STATE
Washington D.C. | | | 13b. CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET ADDRESS
4848 Crescent St. N.W. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Bernard Clements | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Effie Mae Greer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
718-14-9887 | | 17. INFORMANT
ADDRESS
Sister Maureen 601 Maiden Choice La. 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Self Extubation</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
45 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Pt. was dying of cardiovascular failure secondary to extensive bleeding into her pleural space.</u> | | | | | |
| 19a. DATE OF OPERATION
12/16 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>87</u> , to <u>12/16</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Timothy D. Nichols</u> | | DEGREE
MD | | 22c. DATE SIGNED
12/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Timothy D. Nichols | | 22e. ADDRESS
St. Agnes Hospital, 900 Eaton Ave. Balt., MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/21/87 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | ADDRESS
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |



076740 DEC 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34518

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ANNE N. CLOCKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 29 87 | | 2b. HOUR
5:00 AM |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 18 1929 | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | 12b. KIND OF BUSINESS OR INDUSTRY
SURGICAL SUPPLY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD. | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4319 GREENHILL AVE. 21206 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HARRY ECKENRODE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
KATHARINE KRAUSE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
218-26-2234 | 17. INFORMANT ADDRESS
ALBERT CLOCKER (HUSBAND) SAME ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Emboli
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16 | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28/87, 19 87, to 12/29/87, 19 87, that (I) (we) last saw the deceased alive on 12/29/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
MEKON HAJ NAZARIAN | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
Good Samaritan Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | 23b. DATE
1/2/88 | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD | 23d. LOCATION
BALTIMORE COUNTY MD. STATE | | |
| 24. FUNERAL DIRECTOR
SCHMUNK FUNERAL HOME, INC. | | 3331 Brehms Lane
Balto. Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | |
| | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

X

100-100-100

100-100-100

075701 DEC 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34519

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|-------------------------|--|---------------------------------|--|---|--|------------------------------|--|--|--|--------------------------------------|--|---------------------------|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME
(TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| | | WILLIAM Frank COAKLEY | | Male | | White | | 12/11/1938 | | 49 YRS | | Wash., DC | | USA | | | | BALTIMORE CITY MD. | | BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | Laborer | | Repair Work | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | | | |
| Maryland | | --- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 221 Pontiac Ave., 21225 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | |
| George W. Coakley, Sr. | | Elizabeth | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| no | | 212-38-4816 | | George W. Coakley, Jr. | | Same as #13 | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF (b) | | 21. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | |
| 9299 | | Cardiopulmonary arrest | | Head trauma | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/29, 1987, to 12/16/1987, that (I) (we) lost saw the deceased alive on 12/16/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | |
| W. El-Dairy | | MD | | 12/16/87 | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 600 N. Wolfe St. Baltimore MD 21205 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | | | | | | | | | | | |
| Cremation | | 12/17/87 | | Security Process, Inc. | | Catonsville, Balto. Md. | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |
| McCully Funeral Homes Balto., Md. 21225 | | DEC 21 1987 | | Julia Benson-Randall | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

OSL 3
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
RELEASED ON APPROVAL DR. A. DIXON PER MR. HENRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "PEN-CULTURE" and "FIBER" are faintly visible.]



076962 JAN -5 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 34520

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

John

B.

Coates

3. SEX

MALE

4. RACE

BLACK

5. DATE OF BIRTH

04-20-20

6. AGE (IN YEARS)

67 YRS.

IF UNDER 1 YR.

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

2a. DATE KNOWN
OF DEATH ESTI-
MATED

12-24-1987

2b. HOUR
M

2c. DATE
PRONOUNCED
DEAD

12-28-1987

2d. HOUR
M

7. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

MICHIAN

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

1604 W. Fayette Street

12a. USUAL OCCUPATION (TYPE OF WORK)

RETIRED

12b. KIND OF BUSINESS

OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1604 WEST FAYETTE STREET

14. FATHER'S NAME

ALBERT

MIDDLE

LAST

COATES

15. MOTHER'S MAIDEN NAME

SARAH

MIDDLE

LAST

JACKSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

YES

(IF YES, GIVE WAR OR DATES)

1942

16b. SOCIAL SECURITY NO.

217-01-5591

17. INFORMANT

LILLIAN FEE

ADDRESS

4643 MANORDENE ROAD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Charles P. Kokes

M.D.

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED

12-29-87

EXAMINER'S NAME (TYPE OR PRINT)

Charles P. Kokes, M.D.

ADDRESS 111 Penn St., Baltimore, Md 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

12-31-87

23c. NAME OF CEMETERY OR CREMATORY

WESTVIEW CREMATORY

23d. LOCATION

BALTIMORE, MARYLAND

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

BROWN/THOMPSON FUNERAL HOME

P.O. BOX 4433 (21223)

25a. DATE REC'D. BY REGISTRAR

JAN 4 1988

25b. REGISTRAR'S SIGNATURE

John Anderson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH OTHER FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

50000-100000

REBIL MOTION 5000

50000-100000

50000-100000

073328 NOV 20 1987

Items 4, 13, 15 per phone -
FOR STATE REGISTRAR
DATE Recd. 12/17/87 DMS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 3 4 5 2 1

| | | | | | |
|--|--|--|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
BABY GIRL COFTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11 17 87 | | 2b. HOUR
208 P.M. |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
11 17 87 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
2 2 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
md | 13b. COUNTY | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sharon COFTON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). EXTREME IMMATURITY
DUE TO, OR AS A CONSEQUENCE OF
(b). THERAPEUTIC ABORTION
DUE TO, OR AS A CONSEQUENCE OF
(c). | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/17, 19 87, to 11/17, 19 87, that (1) (we) last saw the deceased alive on 11/17/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
Stacey A. Hinderlitz M.D. | | | | 22c. DATE SIGNED
11/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STACEY A. HINDERLITZ M.D. | | | | 22e. ADDRESS
FRANCIS SCOTT KEY | |

| | | | |
|---|-----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
cremation | 23b. DATE
11-23-87 | 23c. NAME OF CEMETERY OR CREMATORY
FSKMC | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
FSKMC 4940 Eastern Ave Balt, Md 21224 | | | 25a. DATE REC'D. BY REGISTRAR
NOV 25 1987 |
| 25b. REGISTRAR'S SIGNATURE
John Anderson-Bader | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 3 from pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE NEW YORK 17, N.Y.

073328 MAR 20 1971

30% COTTON EISEN

DAVID

MILITARY



075006 DEC 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 5 2 2
REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PINKNEY COHEN | | | 20. DATE OF DEATH
MONTH DAY YEAR
12 12 87 | | | 21. HOUR
12:55A | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
07 17 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CATON MANOR NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN/DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY
BREWERY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN COHEN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN UNKNOWN | | 16. ADDRESS
GLEN BURNIE MD
DENSIL PRESSLEY 7103 AVESBURY LANE 21061 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 212-01-6514 | | 17. INFORMANT
ADDRESS
DENSIL PRESSLEY 7103 AVESBURY LANE 21061 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>probable cardiac arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metabolic acidosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>renal and hepatic failure</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>severe cachexia with question of occult malignancy</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
July 15 19 87 | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE
3708 Mountain Rd Pasadena Baltimore Maryland | | 21d. I certify that (I) (this hospital) attended the deceased from <u>December 12 19 87</u> to <u>December 12 19 87</u> that (I) (we) <u>(did)</u> saw the deceased alive on <u>December 12 19 87</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(did)</u> (did not) view the body after death. | |
| 22a. SIGNATURE
Jerry D. Skarbek | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-12-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JERRY D. SKARBEK | | 22e. ADDRESS
3708 Mountain Rd Pasadena Baltimore Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WOODLAWN BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
LEROY M & RUSSELL C WITZKE FUNERAL HOME
1630 EDMONDSON AVE CATONSVILLE MD 21228 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

STANDARD FORM NO. 64

148

NO. 1
%
COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8734523 | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>COHEN, SIGMUND</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>Dec 25 1987</u> | |
| 3. SEX <u>MALE</u> | | 4. RACE <u>WHITE</u> | | 5. DATE OF BIRTH <u>SEPT. 22, 1910</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> | |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>2707 JENNER DR., APT. A</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD. | |
| 13a. STATE <u>MARYLAND</u> | | 13b. COUNTY <u>BALTIMORE</u> | | 13c. CITY OR TOWN <u>BALTIMORE</u> | |
| 14. FATHER'S NAME <u>HARRY</u> | | 15. MOTHER'S MAIDEN NAME <u>BELLE</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>215-07-4042</u> | | 17. INFORMANT <u>MRS. EVA COHEN</u> ADDRESS <u>2707 JENNER DR., APT. A #21209</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CVA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) _____ | | 21f. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____ | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 20</u> , 19 <u>87</u> , to <u>DEC 25</u> , 19 <u>87</u> that (I/we) last saw the deceased alive on <u>NOV 20</u> , 19 <u>87</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u> | | | | 22c. DATE SIGNED _____ | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LEON A. SHOFER, MD</u> | | | | 22e. ADDRESS <u>6715 NANK HIGHLANDS AVE</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>12-27-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>AITZ CHAIM</u> | |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., INC.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 30 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |
| 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | | |

BP

074723 DEC 1

07 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34524

| | | | | | |
|---|---|--|---|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BEVERLY ANN COLE | | | 2a DATE OF DEATH
MONTH DAY YEAR
DECEMBER 5, 1987 | | 2b HOUR
7:42 P M |
| 3 SEX
Female | 4 RACE
Black | 5 DATE OF BIRTH
MONTH DAY YEAR
Oct. 30, 1943 | | 6 AGE (IN YEARS LAST BIRTHDAY)
44 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b KIND OF BUSINESS OR INDUSTRY
High School |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Md. | | 13b COUNTY
Carroll | 13c CITY OR TOWN
Hampstead | 13d INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Edward Lane | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E. Davis | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
212-42-9264 | | 17 INFORMANT
ADDRESS
1116 S. Main St.,
Willie J. Cole, Jr. Hampstead, Md. 21074 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE BREAST | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
20 MONTHS |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
MALIGNANT PLEURAL EFFUSION | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (a) (this hospital) attended the deceased from DECEMBER 2, 19 87 , to DECEMBER 5, 19 87 , that (a) (we) last saw the deceased alive on DECEMBER 5, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
<i>Roy Ziegelstein</i> | | DEGREE | | 22c DATE SIGNED
DECEMBER 5, 1987 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
ROY ZIEGELSTEIN | | 22e ADDRESS
606 N. Wolfe St. Balto. Md. 21205-
JOHNS HOPKINS HOSPITAL | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
Dec. 8, 1987 | | 23c NAME OF CEMETERY OR CREMATORY
All Saints Cemetery | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
Reisterstown, Balto, Md. | | | | | |
| 24 FUNERAL DIRECTOR
<i>H. J. Schmitt</i> | | ADDRESS
Owings Mills, Md. | | 25a DATE REC'D. BY REGISTRAR
DEC 10 1987 | |
| | | | | 25b REGISTRAR'S SIGNATURE
<i>John R. Anderson</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of this certificate and file them in the file of the deceased with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other physical cause of death, the medical examiner must be notified at once.

BP

074217 DEC-7 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34525

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SOPHIA J. COLEMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-2-87 | | 2b. HOUR
9:30 A.M. |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
9 7 40 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U-S-A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secour Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Norman Peterson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Floyetta Peterson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
245-64-0648 | | 17. INFORMANT
ADDRESS Silver Spring, Md
Carolyn D. Peterson Legate Terrace, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC OVARIAN CA | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 87 , to 12/2 , 19 87 , that (I) (we) lost saw the deceased alive on 12/1 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Philip Konis | | DEGREE | | 22c. DATE SIGNED
12-2-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Philip Konis | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/5/87 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westport, Maryland |
| 24. FUNERAL DIRECTOR
CHARLES A. RICE
FUNERAL SERVICE, PA
1300 ELITAW PLACE | | 25a. DATE REC'D. BY REGISTRAR
DEC-4 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10-10-71 11:34 TO

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-71 BY SP-10

077758 JAN 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8734526

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DANIEL LEON COMEGYS, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 1987 | | 2b. HOUR
11:15 M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
04 01 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1707 Ashburton Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodian | 12b. KIND OF BUSINESS OR INDUSTRY
Western Elect. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1707 Ashburton St. Baltimore, Md. 21216 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel Comegys | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maggie Sutton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No. | 16b. SOCIAL SECURITY NO.
220-07-2528 | 17. INFORMANT
Mrs. Baltimore, Maryland
Alice Comegys 1707 Ashburton St. 21216 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Coronary Artery Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Essential Hypertension</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10-20 MIN</u>
<u>Years</u>
<u>18 Years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Cirrhosis of Liver</u> | | | | | |
| 19a. DATE OF OPERATION
— | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-14</u> , 19 <u>67</u> , to <u>12-30</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12-29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>James D. Solomon</u> | | DEGREE
<u>M.D.</u> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1-7-88</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>James D. Solomon, M.D.</u> | | 22e. ADDRESS
<u>1919 Ruxton Ave. Balto. 21216</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
<u>1/04/1988</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arbutus Memorial Park</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore, Maryland</u> | | |
| 24. FUNERAL HOME
NAME
<u>NUFNER FUNERAL HOMES, INC.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>JAN 7 1988</u> | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |
| 25c. ADDRESS
<u>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</u> | | | | | |

0551-1157

RECEIVED
FEB 11 1957



075392 DEC

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|---|--|--|--|--|
| FOR STATE REGISTRAR | | | | | REG. NO. 34527 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
THERESA (WARD) CONAWAY | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 13 87 | | | 2b. HOUR
M | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 11 32 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
55 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2408 EAST HOFFMAN STREET | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
21213
2408 E. HOFFMAN STREET | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BENJAMIN SAVAGE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH JOHNSON | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-28-3343 | | 17. INFORMANT
ADDRESS
ANDREW WARD 2501 GARRISON BOULEVARD | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest (unwitnessed)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible Myocardial Plugging</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 11, 1987</u> to <u>November 23, 1987</u> that (I) (we) last saw the deceased alive on <u>April 11, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>RA Clayton</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/14/87</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>RA Clayton</u> | | | | | 22e. ADDRESS
<u>22 S. Greene St Balto Md 21201</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNE ARUNDEL CO. MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1987 | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Ed. Friedman-Randall</u> | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner should be notified.

1123312 00111

BOXES COTTON EIGHT

1000
W
K
T
H
I
S



074622 DEC 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 5 2 8
REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST: John MIDDLE: H. LAST: Conley | | | 2a. DATE OF DEATH
MONTH: December DAY: 4 YEAR: 1987 | | 2b. HOUR
11:58PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH: September DAY: 28 YEAR: 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | IF UNDER 1 YEAR
MONTHS: DAYS: HOURS: MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Minnesota | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4008 Third Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY
Ship- Building |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST: John MIDDLE: A. LAST: Conley | | 15. MOTHER'S MAIDEN NAME
FIRST: Maryellen MIDDLE: Guerard LAST: Guerard | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
213-01-2353 | | 17. INFORMANT
ADDRESS: Constance E. Conley Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Generalized Metastatic Melanoma</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>Melanoma</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a-c. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 <u>84</u> to <u>4th</u> 19 <u>87</u> , that (1) (we) lost
saw the deceased alive on <u>Nov</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>August D. King Jr. MD</u> | | DEGREE
MD | | 22c. DATE SIGNED
12-9-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
August D. King Jr. MD | | 22e. ADDRESS
333 St. Paul Place - Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
12/7/87 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN: Baltimore COUNTY: A.A. STATE: Md | |
| 24. FUNERAL DIRECTOR
NAME: George J. Gonce 4001 Ritchie Hwy Balto Md ADDRESS: | | | | 25a. DATE REC'D. BY REGISTRAR
DEC - 9 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Simon-Randall</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

101-55870
[Faint, mostly illegible text and markings, possibly a stamp or signature area]

101-55870
[Faint, mostly illegible text and markings, possibly a stamp or signature area]

076323 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34529

| | | | | |
|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MYRTLE CONLEY | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-22-87 | | 2b. HOUR
7:30 AM |
| 3. SEX
FEMALE | 4. RACE
CAUC. | 5. DATE OF BIRTH
MONTH DAY YEAR
1-2-01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
WEST VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
625 S. BRADFORD ST. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
(FIRST MIDDLE LAST)
GEORGE SIMMONS | | 15. MOTHER'S MAIDEN NAME
(FIRST MIDDLE LAST)
JANE COTRELL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
234-363125 | | 17. INFORMANT
ADDRESS
MRS MARY NOWAKOWSKI SAME |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Breast Cancer
DUE TO, OR AS A CONSEQUENCE OF
(b) Extensive Metastasis (Bone)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
COOPD - CHF | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, INDICATE MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1969 19 11-21-87 to 12-22 19 87 , that (1) (we) lost
saw the deceased alive on 11-21-87 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (b) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Theodore Niznik | | DEGREE
M.D. | 22c. DATE SIGNED
12-23-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. T. NIZNIK | | 22e. ADDRESS
429 S. Chester St | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12-24-87 | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS of Faith | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE Co. MD | |
| 24. FUNERAL DIRECTOR
NAME
KACZOROWSKI FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1987 | | |
| ADDRESS
2525 FLEET ST. | | 25b. REGISTRAR'S SIGNATURE
Julia Benson-Rudner | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1002 E. 20th St.

RECEIVED 1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

1002 E. 20th St.

077412 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34530

| | | | | | |
|--|---------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | HOURS MIN. | |
| Helan Louise Connelly | | 12 30 87 | | 6:25 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | white | MONTH DAY YEAR | | 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Maryland | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | S. Balt. Gen. Hosp | | Ret. Housewife | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD. | | Balt. | | Balt. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 16b. SOCIAL SECURITY NO. | |
| Melvin D. Lindsay | | Annie Ruff | | 214243806 | |
| 17. INFORMANT | | ADDRESS | | 17. INFORMANT | |
| R. Wudrick | | 3001 S. Hanover St. | | R. Wudrick | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>(suspected)</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>12-27</u> , 19 <u>87</u> , to <u>12-29</u> , 19 <u>87</u> , that (I) <u>we</u> lost saw the deceased live on <u>12-29</u> , 19 <u>87</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above (I) <u>we</u> did not see the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>R. Wudrick</u> | | MD. | | 12/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| <u>R. Wudrick</u> | | 3001 S. Hanover ST. Balt. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 1/2/88 | | Glen Haven Mem Pk | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | JAN 5 1988 | | <u>Julia Gordon-Ruback</u> | |
| McCully Funeral Homes Balto., Md. 21225 | | | | | |

BP

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a list or table structure.]

076509 DEC 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34531

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Clara E. Connolly | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 27, 1987 | | 2b. HOUR
8:00 A.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
04 17 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
-- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3622 Roland Avenue 21211 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Hands | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Birdie Medcalp | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
-- | 17. INFORMANT ADDRESS
William Connolly 11412 Mays Chapel Rd. 21093 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 HRS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21/87, 19 87, to 12/27/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/29 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/30/87 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz, Jr. | | ADDRESS
3818 Roland Ave. 21211 | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1987 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

071803 NOV 16

FOR
STATE
REGISTRAR

per funeral home

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO. 8 7 3 4 5 3 2

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BIRDELLA - COOK | | 2a. DATE OF DEATH
MONTH YEAR DAY
11 4 87 | | 2b. HOUR
9:16 PM | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 07 97 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 7b. IF UNDER 24 HRS.
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
? | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
housewife | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSPITAL | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS / ZIP CODE
1213 Light St. Balto md. 21230 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unavailable | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unavailable | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
213-36-2481 | | 17. INFORMANT
Vavinia Cook | | 17. ADDRESS
612 S. Paca St. 21230 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) slips , (b) decubitus ulcer | | | | | |
| 19a. DATE OF OPERATION
10/27/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
large ulcer left buttock | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Rafael Aybar | | DEGREE
MD | | 22c. DATE SIGNED
11/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAFAEL AYBAR | | 22e. ADDRESS
10706 Potomac Rd, Spring Mill | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
11/7/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westport Md. | | 25a. DATE REC'D BY REGISTRAR
NOV 13 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Estep Bros. F.H. 1300 Eutaw Pl. | | 25b. REGISTRAR'S SIGNATURE
Julia Bender-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

7 1 3 3 8 1 1 6 1 0

077416 JAN - 7 89

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34533

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary S. Cook | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 29, 1987 | | 2b. HOUR
8:35 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
September 10, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Baltimore Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
111 Dundalk Ave. 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Karol Duda | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Wegenzy | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-76-2096 | 17. INFORMANT ADDRESS
Helen Cook 111 Dundalk Ave. 21222 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
P. Keian | | | | DEGREE | 22c. DATE SIGNED
12/29/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-2-88 | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Mary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck Funeral Home of Dundalk
7922 Wise Ave. Dundalk, MD 21222 | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1988 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

29

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

0111 11110

RECEIVED

10/12/77

10/12/77

10/12/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4 5 3 4

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|-----------------------------------|--|---|--|-------------------------|--|--------------------------------------|--|--|--|
| FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Muriel | | MIDDLE | | LAST Cook | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 10:28 | |
| Female | | Caucasian | | June 9, 1920 | | 67 YRS. | | MONTHS | | DAYS | | 12/ 20/87 | | a m | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| New York | | U.S.A. | | MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | Key Medical Center | | Homemaker | | Home | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 99999 | | | | | |
| New York | | N/A | | West Islip | | YES NO | | 495 Milligan Lane | | 11795 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| George | | | | Janos | | | | Pearl | | | | Klein | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | 132-09-9610 | | | | Leo Cook (husband) | | | | Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES NO | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | STREET | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inquiry, and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | | | |
| 22b. I certify that I took charge of the remains described above, held an Autopsy Inquiry, and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| Dennis F. Smyth, M.D. | | | | Assistant | | | | 12/21/87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Burial | | | | 23 Dec 87 | | | | Mt. Ararat Cemetery | | | | Farmingdale, NY | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Capitol Funeral Service, Falls Church, Virginia | | | | DEC 23 1987 | | | | J. E. Anderson | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))

070

Waste Converter, Inc. 1960

U.S.A.

Home

107-00-0010 (see back (in n.d.)

107-00-0010 (see back (in n.d.)

107-00-0010

WILLIAMS

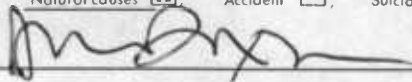

23 Dec 87

23 Dec 87

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **34535**

FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---------------------|---|---|---|------------------|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALMA R. COOPER | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 12 87 | | | 2b. HOUR 6:30 P.M. | | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR 7 11 23 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 63 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 12 12 87 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2123 Wilhelm St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JEFFERSON JEROME WALSH | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 13e. STREET ADDRESS
2123 WILHELM ST. 21223 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-14-5665 | | 17. INFORMANT ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
Deputy Chief | | M.D. | | DATE SIGNED
12-13-87 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
12-14-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
State Anatomy Board Balto., Md. | | 25a. DATE EC.D. REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
 | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE DATES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THE REMAINS, IF RETAIN RANGE \$100 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DEC 15 1987

70-1091-243

076669 DEC 31

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

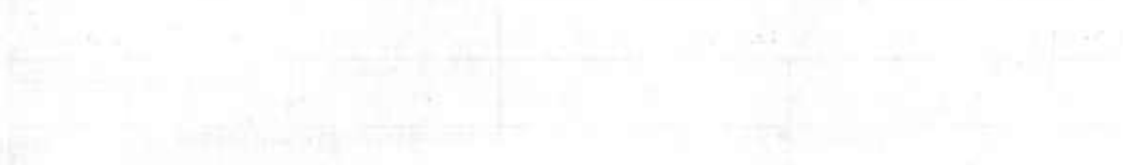
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34536

| | | | | | | | |
|---|--|---|--|---|--------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Lydia M. Corbin | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 87 | | 2b. HOUR
8:05 A
M | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 18 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78
YRS MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2528 DRUID HILL AVENUE 21217 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
RICHARD PROSSER COOK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PINKEY DIXON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
223-33-1886 | | 17. INFORMANT
EVELYN LUCAS | | ADDRESS
2528 DRUID HILL AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Exsanguination
(c) Liver Failure | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 min. | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | |
| 19a. DATE OF OPERATION
12/15/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gastrocutaneous Fistula/Abcess | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (x) (this hospital) attended the deceased from December 15 , 19 87 , to December 26 , 19 87 , that (1) (we) last saw the deceased alive on December 26 , 19 87 , and that (2) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
Attending Physician | | 22c. DATE SIGNED
12/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Fischgrund | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/ 31/87 | | 23c. NAME OF CEMETERY OR CREMATORY
COOK CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BENA VA | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |



Speed vs. Time graph showing constant acceleration. The line starts at the origin (0,0) and rises linearly to approximately (10, 10). The x-axis is labeled 'Time' and the y-axis is labeled 'Speed'.

The graph shows a constant rate of change in speed over time, which is characteristic of constant acceleration. The slope of the line represents the acceleration.

Since the line is straight and passes through the origin, the acceleration is constant and positive. The area under the line represents the distance traveled.

The area under the line is a triangle with a base of 10 units and a height of 10 units. The area is calculated as $\frac{1}{2} \times \text{base} \times \text{height} = \frac{1}{2} \times 10 \times 10 = 50$ units.

The total distance traveled is 50 units. The final speed is 10 units. The final time is 10 units.

077160 JAN - 5 '88

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, brother traumatic event, the medical examiner must be notified at once.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 87 REG. NO. 34537 | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MELVINA CORPREW | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 28 87
2b. HOUR
M | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 1 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1028 EAST 20TH STREET | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13e. STREET ADDRESS / ZIP CODE
1028 EAST 20th STREET 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NATHANIEL PRIDGET | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LILLIE MAE BROWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-22-3877 | | 17. INFORMANT
ADDRESS
ESTELLE CORPREW 526 N. MOUNT STREET | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic Cancer of Lung,</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>non oat cell</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Nov 84</u> | |
| | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-4</u> , 19 <u>85</u> , to <u>12/14</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Stuart H Brager MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/31/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/5/88 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY
BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H, INC. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 - 1988 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |
| ADDRESS
1101 E. NORTH AVENUE | | | | | | | |

2009 02-01-10

2009 02-01-10

2009 02-01-10

076060 DEC 24 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34538

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HERBERT D. COSBY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 21 87 | | 2b. HOUR
5 A M |
| 3. SEX
M | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
2 20 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | 7b. CITIZEN OF WHAT COUNTRY?
U S A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2324 HARLEM AVENUE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2324 Harlem Avenue 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herbert Cosby | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Jannie Ellis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | 16b. SOCIAL SECURITY NO.
218-26-4670 | | 17. INFORMANT
ADDRESS
Jannie F. Cosby 2324 Harlem Avenue | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC COLORECTAL CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 19 87 to Dec 21 19 87 that (I) (we) last saw the deceased alive on Dec 3 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Alexander Hantel MD | | | | 22c. DATE SIGNED
12/21/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALEXANDER HANTEL MD | | 22e. ADDRESS
600 N. WOLFE ST BALTIMORE MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/24/87 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 4300 WABASH AVENUE | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

BP _____

W 75 34 000000

20% COTTON FIBER

WATFALL



76159 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87-34539
REG. NO.

| | | | | | | |
|--|--|---|--|---|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CHARLES Robert COUFAL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC. 22 1987 | | 2b. HOUR
1:15 P.M. | |
| 3. SEX
MALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 3 1916 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Levin Jave Hebrew Geriatric Center & Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired - Century | | 12b. KIND OF BUSINESS OR INDUSTRY
Neon Service | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Owings Mills | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Coufal | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Irene Broadbeck | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
yes WW II | | 16b. SOCIAL SECURITY NO.
217-055956 | | 17. INFORMANT
Mr. Robert C. Coufal ADDRESS
21117 5115 Wards Chapel Road Owings Mills, MD | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (this hospital) attended the deceased from 12/22/87 to 12/22/87 , that (we) last saw the deceased alive on 12/22/87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | 22c. DATE SIGNED
12/22/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ESTRELLITA O. KIM, MD | | 22e. ADDRESS
Levin Jave Hebrew Geriatric Center & Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Baltimore MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD 21133 | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1987 | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

COUFAL, CHARLES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

BP

[Faint, mostly illegible text across the page, possibly bleed-through from the reverse side. Some words like "The", "and", "of", "in" are visible.]

REVISIT 10/10/1910

[Faint handwritten notes or signatures on the right margin.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34540

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|---|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Barbara Lee Thomas Council | | | 2a DATE OF DEATH MONTH DAY YEAR
12 02 87 | | 2b HOUR
2:00 AM |
| 3 SEX
Female | 4 RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 27 1929 | | 6 AGE (IN YEARS LAST BIRTHDAY)
58 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | 7b CITIZEN OF WHAT COUNTRY?
U. S. A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4710 Wrenwood Avenue | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b KIND OF BUSINESS OR
DEPT. OF ED.
Balto. City |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
James Lee Thomas | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Beatrice Greenleaf | | 13e. STREET ADDRESS / ZIP CODE
4710 Wrenwood Ave. Baltimore, Maryland 21212 | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No. | | 16b SOCIAL SECURITY NO.
238-383494 | | 17 INFORMANT Mr. Baltimore, Maryland
Irving C. Council 4710 Wrenwood Ave. 21212 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Widespread Metastatic Breast Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Quadruparesis secondary to spinal cord compression</u> | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (1) (this hospital) attended the deceased from 11/27/87 to 12/2/87, that (1) (we) lost saw the deceased alive on 11/27/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did and not view the body after death. | | | | | |
| 22b SIGNATURE
<i>John Fetting</i> | | DEGREE | | 22c DATE SIGNED
12/4/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
John Fetting MD | | 22e ADDRESS
Johns Hopkins Oncology Center | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
12/07/1987 | 23c NAME OF CEMETERY OR CREMATORY
Maryland Veteran Cem. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Crownsville, Maryland |
| 24 FUNERAL HOME
NAME
NUTTER FUNERAL HOMES, INC. | | ADDRESS
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | 25a DATE REC'D. BY REGISTRAR
DEC 11 1987 | 25b REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> |

BP _____

1

076164 DEC 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 2. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Walter Covington | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 20, 1987 | | 2b. HOUR
3:30am | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 31, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven VA Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Shoe Repairer | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2311 Roslyn Avenue 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Covington | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hosia Broadnax | | ADDRESS Plainfield, NJ 07062 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | 16b. SOCIAL SECURITY NO.
143183633 | | 17. INFORMANT
Earlene Roberts | | 1371 East 7th St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mediastatic Pulmonary Ca.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (X) this hospital attended the deceased from 12/20/87 to 12/20/87, that X (we) last saw the deceased alive on 12/20/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
F. W. Jones, Jr. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/26 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F. W. Jones, Jr. | | | | 22e. ADDRESS
3900 Loch Raven Blvd. Balto. MD 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-23-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vets. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Garrison, Balto. Co., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Marshall W. Jones, Jr | | | | 24b. ADDRESS
21229 Edmondson Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP

2000 COLLECTION LIBRARY

76357 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4542

| | | | | | | | | | | | | | | |
|--|---------|------------------|--|---|------------------|--|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| THOMAS E. COWLS | | | | | | 12-24-87 | | | 12-24-87 | | | 9:30A | | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | 2d. HOUR | | |
| Male | White | July 24 1906 | 81 YRS. | MONTHS | DAYS | 12-24-87 | | | 12-24-87 | | | 9:30A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| England | | | U.S.A. | | | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | 1601 Ramblewood Road | | | Ret. Food Distributor | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| Oregon | | | COUNTY | | | Portland | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 5515 Willamette Blvd. 97203 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| John H. Cowls | | | Nattie Tresidder | | | 540-09-1623 | | | Melvin Govig 7106 Campfield Rd. 21207 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | 17. INFORMANT ADDRESS | | | | | |
| No | | | 540-09-1623 | | | Melvin Govig 7106 Campfield Rd. 21207 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | |
| Margarita A. Korell, M.D. | | | | Assistant | | | | 12-24-87 | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn Street | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Entombment | | | | Dec 30 1987 | | Rose City Cemetery | | | | Portland Oregon | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | |
| Leonard J. Ruck, Inc. | | | | Baltimore, Maryland | | | | DEC 28 1987 | | | | Julia Davidson-Rendell | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))

July 24 1953

U.S.A.

England

Ref. 1000

2517

Portland

London

London

2517

Portland

U.S.A.

London

2517

London



W. J. P. 1000

1000

1000

07 6086 DEC 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 4 5 4 3

| | | | | | | | |
|--|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>FANNIE</u> MIDDLE <u>+</u> LAST <u>CRAVEN</u> | | | 2a. DATE OF DEATH
MONTH <u>12</u> DAY <u>19</u> YEAR <u>87</u> | | 2b. HOUR
<u>11:20am</u> | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH
MONTH <u>4</u> DAY <u>10</u> YEAR <u>00</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>87</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>LITHUANIA</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore</u> MD | |
| 10. CITY OR TOWN OF DEATH
<u>Balto</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Sinai Hosp of Balto</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
<u>MARYLAND</u> | | 13b. COUNTY
<u>BALTIMORE</u> | | 13c. CITY OR TOWN
<u>BALTIMORE</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>EREN</u> MIDDLE <u>ABRAHAM</u> LAST <u>SHAPIRO</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>SARAH</u> MIDDLE <u>+</u> LAST <u>+</u> | | 13e. STREET ADDRESS / ZIP CODE
<u>6930 MARSUE DR., APT. 1D 21215</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>NO</u> | | 17. INFORMANT
ADDRESS
<u>MRS. MIRIAM KIND</u>
<u>818 STURGIS PLACE #21208</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>+</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> 19 <u>87</u> , to <u>12</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Eric Weiner</u> | | | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/19/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Eric Weiner</u> | | | | 22e. ADDRESS
<u>Sinai Hosp of Balto</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>BURIAL</u> | | 23b. DATE
<u>12-21-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>HEBREW YOUNG MEN</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>BALTIMORE MD</u> | |
| 24. FUNERAL DIRECTOR
NAME <u>SOL LEVINSON & BROS., INC.</u>
ADDRESS <u>6010 REISTERSTOWN RD., BALTO., MD 21215</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 23 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

97
12
35
3002
9

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Control

Page 2

17

074225 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

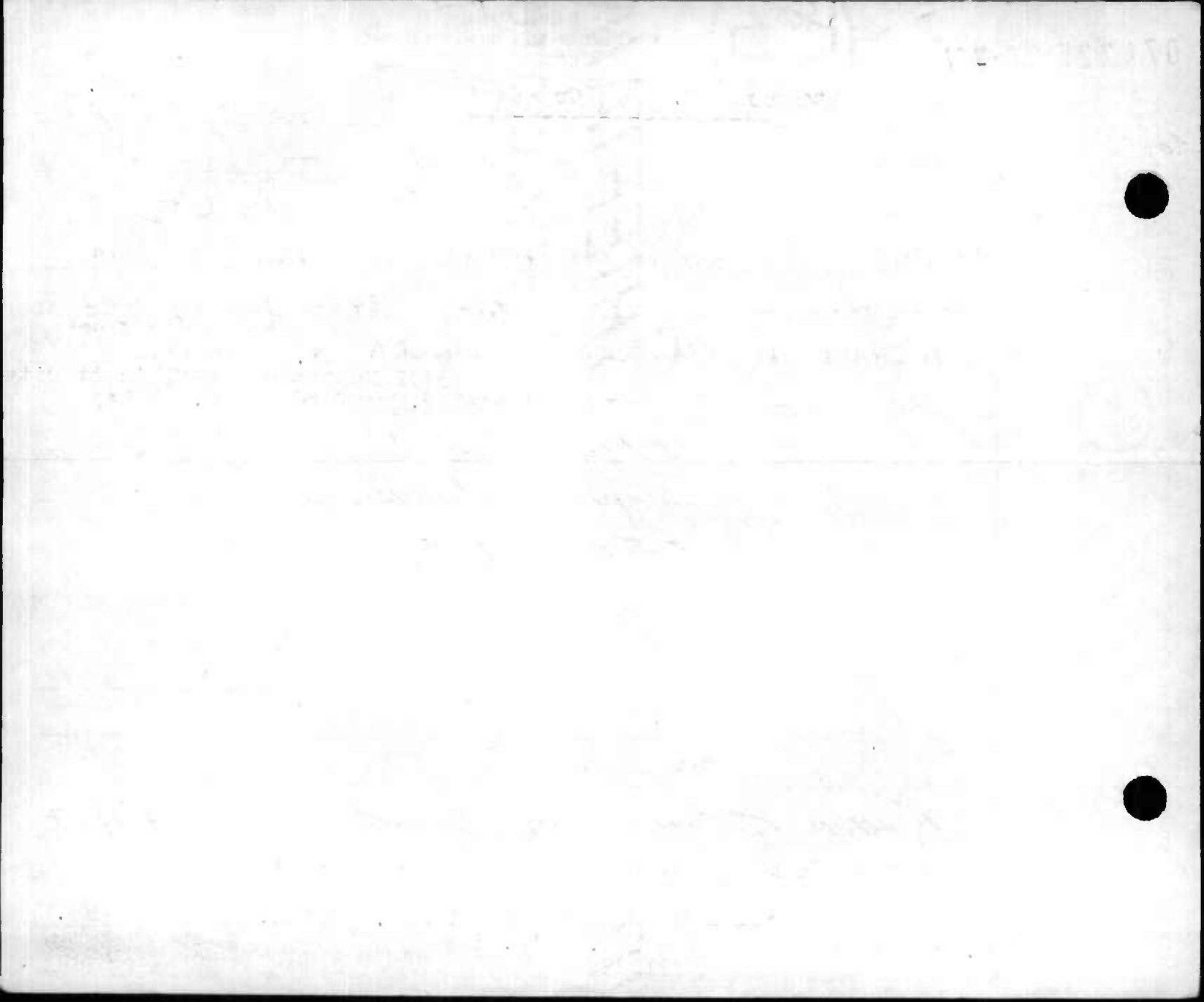
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4544

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Baby (ry) Stephen M Crawford (Sandra) | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 - 2-87 | | 2b. HOUR
7:30 A.M. | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
12 2 87 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
— — — | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
N/A Newborn | | 13b. COUNTY
— | | 13c. CITY OR TOWN
— | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MICHAEL H. CRAWFORD | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SANDRA H. HAWKES | | 16. STREET ADDRESS / ZIP CODE
3432 HUNTSMAN RUN
ELLCOTT CITY Md
21043 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 17b. SOCIAL SECURITY NO.
— | | 17c. INFORMANT
Michael H. Crawford | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) diaphragmatic hernia
DUE TO, OR AS A CONSEQUENCE OF
(c) multiple congenital anomalies
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 HRS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: — | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
5:40 AM 12/2 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5:40 AM 12/2 87 , to 12/2 87 , that (I) (we) last saw the deceased alive on 12/2 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
KATHLEEN STEVENS MD
22c. ADDRESS
Sinai Hospital | | | | 22d. DATE SIGNED
12/2/87 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12-4-87 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | 24. FUNERAL DIRECTOR
G. Truman Schwab 5151 Balto. Nat'l. Pike #21229 | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 03 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rudolph | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

3 4 5 4 5

| | | | | | |
|---|--|--|--|--|--|
| 2a DECEASED NAME
(TYPE OR PRINT)
Georgia F. Cremen | | | 2b DATE OF DEATH
MONTH DAY YEAR
December 20, 1987 | | 2b HOUR
2:15 P.M. |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
March 23, 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a STATE
Maryland | 13b COUNTY
Baltimore | 13c CITY OR TOWN
Baltimore | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
7409 Bay Front Road 21219 |
| 14 FATHER'S NAME
(FIRST MIDDLE LAST)
John Hinson | | 15 MOTHER'S MAIDEN NAME
(FIRST MIDDLE LAST)
Edmonie Freeman | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-68-7523 | 17 INFORMANT ADDRESS
William A. Cremen, Sr. 7409 Bay Front Rd. 21219 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-19 1987, to 12-20 1987, that (I) (we) last saw the deceased alive on 12-20 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
R. Rendleman | | DEGREE
M.D. | | 22c. DATE SIGNED
12-20-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. RENDLEMAN | | 22e. ADDRESS
FSC MEDICAL CENTR Eastern Ave BALTO MD | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12-23-87 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24 FUNERAL DIRECTOR
NAME
Duda-Ruck Funeral Home of Dundalk
7922 Wise Ave. Dundalk, MD 21222 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

DEC 21 1987

172503 100000



074306 DEC 14 1987

1-17, 23a-24 sb

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

87 REG. NO. 34546

1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN CREWS

2a. DATE OF DEATH
MONTH DAY YEAR
12 05 87

2b. HOUR
10:30 AM

3. SEX
(M)

4. RACE
CAUCASIAN

5. DATE OF BIRTH
MONTH DAY YEAR
12 30 06

6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS.

IF UNDER 1 YEAR
MONTHS DAYS

IF UNDER 24 HRS
HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UNKNOWN

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD

10. CITY OR TOWN OF DEATH
BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MT. VERNON CARE CENTER

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNKNOWN

12b. KIND OF BUSINESS OR INDUSTRY
UNKNOWN

13a. STATE
MARYLAND

13b. COUNTY
BALTIMORE

13c. CITY OR TOWN
BALTIMORE

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE
808 N ST PAUL 21202

14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO

16b. SOCIAL SECURITY NO.
182103094

17. INFORMANT
ADDRESS
MR. CHARLES FONNER MT. VERNON CARE CTR

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPTIC SHOCK
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) UROSENSIS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES
HOURS
DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?
YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from December 4 19 87 to Dec 5th 19 87, that (I) (we) last saw the deceased alive on Dec 5th 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death,

22b. SIGNATURE
A. P. Mansury MD
DEGREE MD
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED
12/5/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. P. MANSURY MD

22e. ADDRESS
SOUTH BALT GEN. HOSP

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal

23b. DATE
12-15-87
12-8-87

23c. NAME OF CEMETERY OR CREMATORY
King Memorial Pk.

23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown MD

24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F. Address 1101 E. NORTH
State Anatomy Board Balto., Md. AVE

25a. DATE REC'D. BY REGISTRAR
DEC 10 1987

25b. REGISTRAR'S SIGNATURE
John Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

11-03-03-11

MOBILE

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

11-03-03-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

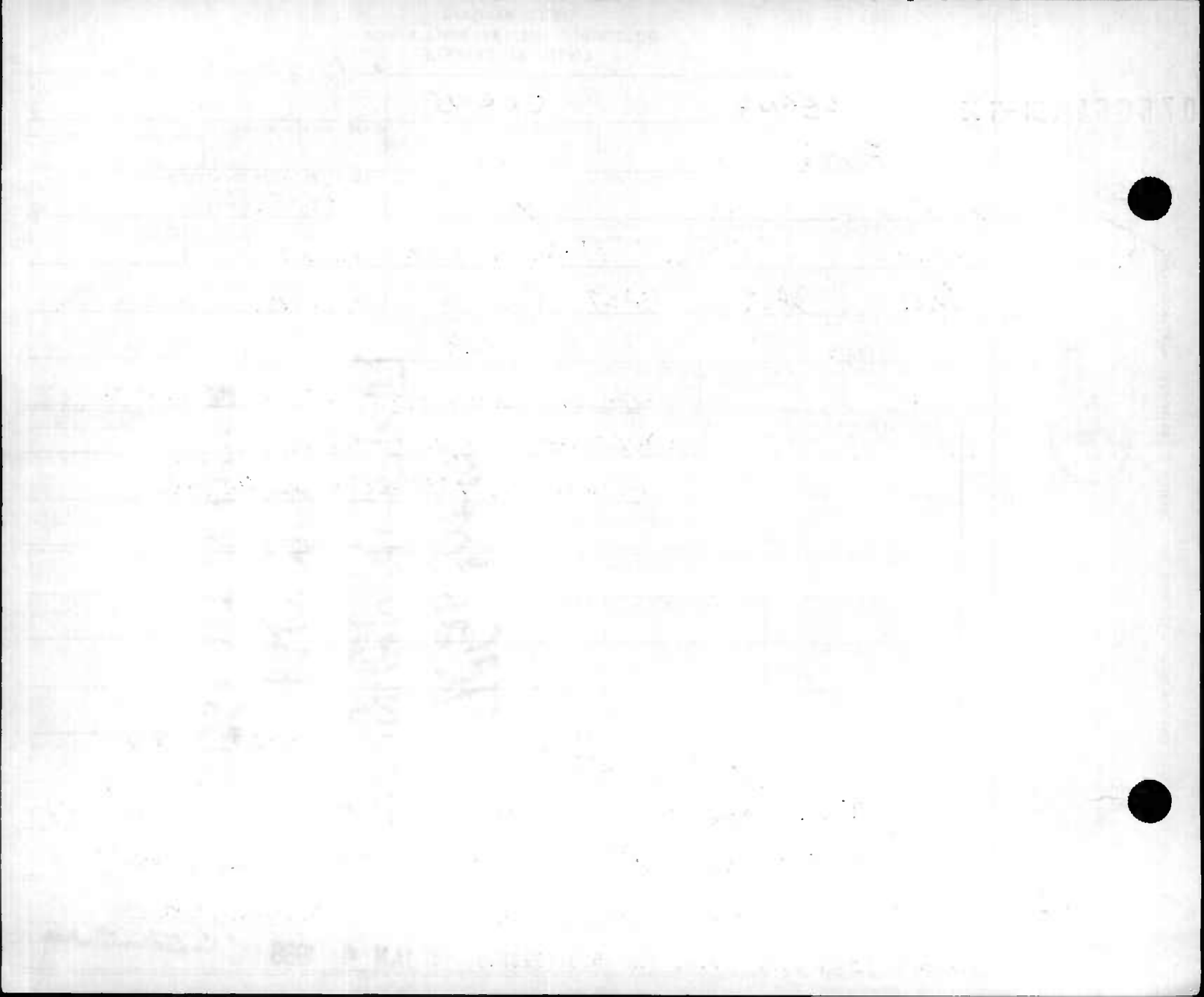
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LEONA CREWS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-26-87 | | | 2b. HOUR
M
4 | |
| 3. SEX
Female | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
06-06-13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
74 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Private Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALT 13c. CITY OR TOWN BALT | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2525 WEST BELVEDERE AVENUE 21223 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LEONA TOLSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-07-1172 | | 17. INFORMANT
ADDRESS
LEONA ROBINSON 5427 JONQUIL AVENUE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADVANCED HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(b) ADVANCED NEUROLOGICAL DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1/87 , 19 87 , to 12/27 , 19 87 , that (I) (we) last saw the deceased alive on 12/18 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Marie Davis MD | | | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARIE DAVIS MD | | | | | 22e. ADDRESS
914 BALTIMORE PIKE EC MD 21043 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-31-87 | | 23c. NAME OF CEMETERY OR CREMATORY
MARYLAND NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
BROWN/THOMPSON F.H. P.O. BOX 4433 (21223) | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 - 1988 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

BP **12**



0.75481 DEC 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to be called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 4543

FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDITH Vance CROMWELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 15 87 | | 2b. HOUR
3:45 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct 12, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerical | 12b. KIND OF BUSINESS OR INDUSTRY
Manufctr | |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
6109 York Road 21212 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jacob Vance | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Nicoll | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-22-1935 | 17. INFORMANT
Kenneth P. Cromwell 2512 Harris Mill Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Inferior Myocardial Infarction (old)</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>2 Mos</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Right Pleural Effusion, Hyponatremia, History of Hypertension</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that this hospital attended the deceased from <u>11/18</u> , 19 <u>87</u> , to <u>12/15</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>12/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>John E. Stokes IV</u> M.D. | | DEGREE | | 22c. DATE SIGNED
12/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN E. STOKES IV, M.D. | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Dec 17, 1987 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
DIPPEL FUNERAL HOME, INC.
7110 Belair Road Baltimore, MD 21206 | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1987 | | | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Pendleton</u> | | | |

BP

10-10-10

ON THE
10-10-10



10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

075260 DEC 16 87

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 4549

| | | | | | | |
|--|---|---|---|---|---|--|
| DECEASED NAME
(TYPE OR PRINT)
Robert Thomas Crouse | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 0 87 | | 2b. HOUR
9 ¹¹ A.M. | |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
6 21 37 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY
Painting | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Crouse | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dollie Eckart | | 13e. STREET ADDRESS / ZIP CODE
2509 Yorkway Apt B 21222 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1956 | 17. INFORMANT
Theodore Crouse | | ADDRESS
Baltimore, Md. | | |
| 8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Ruptured Abdominal Aortic Aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cirrhosis of liver</u> | | | | | | |
| 19a. DATE OF OPERATION
12/8/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Rupturing Abdominal Aortic Aneurysm | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21c. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8 to 12/8, 1987, that (I) (we) lost saw the deceased alive on 12/8, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Selwyn M. Vickers | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/8/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Selwyn M. Vickers | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Kalbaugh Cemetery | | 23d. LOCATION
CITY OR TOWN
Elk Garden Mineral W. Va. |
| 24. FUNERAL DIRECTOR
NAME
David A. Burdock | | ADDRESS
Kitzmilller, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | | |

100 100 0 00 0 00



100 100 0 00 0 00

074295 DEC

item 1 film G635 1-4-88 sh

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

34558

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| DECEASED NAME
(TYPE OR PRINT)
Dolores Dolores | | FIRST
C. | | MIDDLE
Crowell | | LAST
Crowell | | 7a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12/ 4/ 19 87 | | 7b. HOUR
6:10 | |
| 1. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 24 28 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
59 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN
59 | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12/ 4/ 19 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | 12c. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
15 N. Eden St. | | 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
VERNON BUSTER WRITE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VELMA EDWARDS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-20-6931 | | 17. INFORMANT
DELORES McCORD | | ADDRESS
3732 ELMORA AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Diabetes Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from _____ Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | DATE (SPECIFY)
12/ 4/ 87 | | | | | | | | DATE SIGNED
12/ 4/ 87 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/8/87 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PK. CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARBUTUS MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H | | ADDRESS
1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR
DEC - 7 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>John William Randle</i> | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

03/14
25A

BP

DHMH - 17
(VR A15 ME (5))

01458E K-01

24000

93017 100% COTTON

WINTER 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then page 3 should be attached to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 7 3 4 5 5 2 | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(Last, first, middle)
George Crusse | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/29/87 | | 2b. HOUR
MIN.
12:31 PM |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
8 26 33 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self Emp. Auto Repair | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. CITY OR TOWN Baltimore 13c. CITY OR TOWN Edgemere | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
9107 B. Ave. 21219 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Francis Crusse | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Ann Greska | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korea 214-30-6647 | 17. INFORMANT
ADDRESS
Janice M. Crusse Same as 13e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 28, 1987 , to Dec 29, 1987 , that (I) (we) lost
saw the deceased alive on Dec 29, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Philip Keiser | | DEGREE
P. Keiser | | 22c. DATE SIGNED
12/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. Keiser | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
1-2-88 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME Duda-Ruck Funeral Home of Dundalk
ADDRESS 7922 Wise Ave. Dundalk, MD 21222 | | | 25a. DATE REC'D. BY REGISTRAR JAN 5 1988 25b. REGISTRAR'S SIGNATURE
Jahiri Roudan Roudan | | |

BP

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

C

74940 DEC 15 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 1 REG. NO. 4 5 5 3

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALBERT R. CUCINA | | | 2a. DATE OF DEATH
MONTH 12 DAY 14 YEAR 87 | | | 2b. HOUR
3:12 A | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 6 DAY 9 YEAR 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hosp. Balto. Md. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer, Chesapeake Box | | 12b. KIND OF BUSINESS OR INDUSTRY
21230 | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
----- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
111 E. Ostend St. Balto. Md. | |
| 14. FATHER'S NAME
FIRST Anthony MIDDLE ----- LAST Cucina | | | | 15. MOTHER'S MAIDEN NAME
FIRST Joshanna MIDDLE ----- LAST Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W.2 | | 17. INFORMANT
Hope S. Cucina, 1223 William St. Balto. | | ADDRESS
Md. 21230 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTIONS
DUE TO, OR AS A CONSEQUENCE OF
(b) VENTRICULAR ARRHYTHMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) STAPHYLOCOCCAL PNEUMONIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
CJ Nesbitt MD | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/14/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CJ NESBITT | | | 22e. ADDRESS
Mercy Hospital
301 St Paul Pl Mercy Hosp. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Crementation | | | 23b. DATE
12/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process, Inc. Catonsville, Balto. Co. Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Home, 130 E. Fort Ave. | | | 24b. ADDRESS
Balto. Md. 21230 | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after the traumatic event, the medical examiner must be notified at once.

BP _____

521-2004-7

077441 JAN 17 88

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 4554

| | | | | | | |
|--|--|--|--|--|-----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ida Delano Cullison | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 25, 1987 | | 2b. HOUR
9:40 p.m. | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 30, 1897 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | 10. CITY OR TOWN OF DEATH
Baltimore | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Cockeysville | | 13c. STREET ADDRESS / ZIP CODE
13801 York Road 21030 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Henry Delano | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Snyder | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b. SOCIAL SECURITY NO.
214 22 7994 | | 17. INFORMANT
Mrs. Harriet C. Quandt | | ADDRESS
110 Bellemore Rd. 21210 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PROB CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>Dec. 25th 1987</u> | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>8:23pm Dec 25th 1987</u> , to <u>9:55pm Dec 25th 1987</u> , that (I) (we) last saw the deceased alive on <u>DDA</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>A. A. Silva M.D.</u> | | |
| 22c. DATE SIGNED
12/27/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DASILVA | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL
LOCH RAVEN BOULEVARD, BALTIMORE, MD | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Cem. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1988 | | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Call for more...

1911, 7, 20

1950

at 3000

profits

Indigo returns of 1900

U. S. C.

el'li'se'of ero'le's

150 1007 10001

o slo tre' rean

ACORN SS MS

[illegible]

1950

1950

615-617

075883 DEC 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34555 | | | |
|---|--|---------------|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| DECEASED NAME (NAME OR PRINT) Robert Andrew Cuprik | | | | | | | | | | ESTIMATED MONTH DAY YEAR 12 18 19 87 | | M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 28, 1951 | | 6. AGE (IN YEARS) LAST BIRTHDAY 36 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 18 19 87 | | 2d. HOUR 10:35 P M | |
| 7a. BIRTHPLACE (STATE OR COUNTRY) Balto., Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Air Cond. Mechanic | | | | 12b. KIND OF BUSINESS OR INDUSTRY Coast Guard | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6715 Woodley Rd. 21222 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew J. Cuprik | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stelnack | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216.58.1047 | | 17. INFORMANT ADDRESS Andrew J. Cuprik (Same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8151 IMMEDIATE CAUSE (a). Thoraco-abdominal injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 9:15 P.M. 12 18 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Passenger in auto/auto impact | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5300 Blk. Pennington Ave, Balto. MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Mario F. Golle, Jr. | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER DATE SIGNED 12/19/87 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. | | | | ADDRESS 111 Penn St. | | | | Balto. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12.22.1987 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. | | | | ADDRESS Dundalk Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

07/84
35MDHMH - 17
(VR A15 ME (5))

076849 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them in the 72-hour office death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34556

REG. NO.

| | | | | | | |
|--|--|---|---|--|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>John Curtis</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>December 28, 1987</i> | | 2b. HOUR
<i>5:23A</i> M | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>4 20 1915</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Md</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U S A</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
<i>72</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Maryland General Hospital</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | |
| 13a. STATE
<i>Md</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Eugene Curtis</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Florence Thomas</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Dept of Ed. Balto</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>215-05-6571</i> | | 17. INFORMANT
ADDRESS
<i>Evelyn Curtis 4812 Laurel Avenue</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Septic shock</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Chronic obstructive pulmonary disease</i> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | | | | |
| 19a. DATE OF OPERATION
<i>November 12, 87</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Ischemia, severe, right leg</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>November 10, 87</i> to <i>December 28, 1987</i> , that <input checked="" type="checkbox"/> (we) lost sight of the deceased alive on <i>December 28, 1987</i> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | 22b. SIGNATURE
<i>Krishnan Raghavan</i> | | |
| 22c. DATE SIGNED
<i>12/28/87</i> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Krishnan Raghavan, M.D.</i> | | 22e. ADDRESS
<i>c/o Maryland General Hospital</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/31/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arbutus Memorial Park</i> | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Arbutus Md</i> | | 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Wm. C. March F/H West 4300 Wabash Avenue</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 30 1987</i> | | |
| 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson</i> | | | | | | |

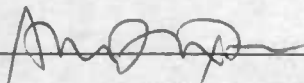
MEDICAL CERTIFICATION

75513 DEC 21 1987

UNAWAY #87-135

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 34557

| | | | | | | | |
|---|------------------|--|---|---|---|---|-----------------------------------|
| 1- FOR STATE REGISTRAR | | DECEASED NAME
FIRST MIDDLE LAST
SHARON E. CURTIS | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12 13 19 87 | | 7b. HOUR
M
M | |
| 3 SEX
female | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 5 1961 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
26 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 13 19 87 | 7d. HOUR
9A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
rear of 2301 Tioga Pkwy. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
3142 Virginia Avenue | | 13f. CITY OR TOWN
Baltimore | | 13g. STREET ADDRESS
21215 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leroy Brown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Mary Brown 4002 Ayrdale Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot wounds of head</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
xxx 12-13- 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot. | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
rear of | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2301 Tioga Pkwy., Balto. MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Deputy Chief | | MEDICAL EXAMINER | | DATE SIGNED
12-13-87 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H West 4300 Wabash Avenue | | | | 25. DATE REC'D. BY REGISTRAR
DEC 18 1987 | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PH 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))

12-13-1963

20% cotton 100% wool

DEC 16 1963

176673 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

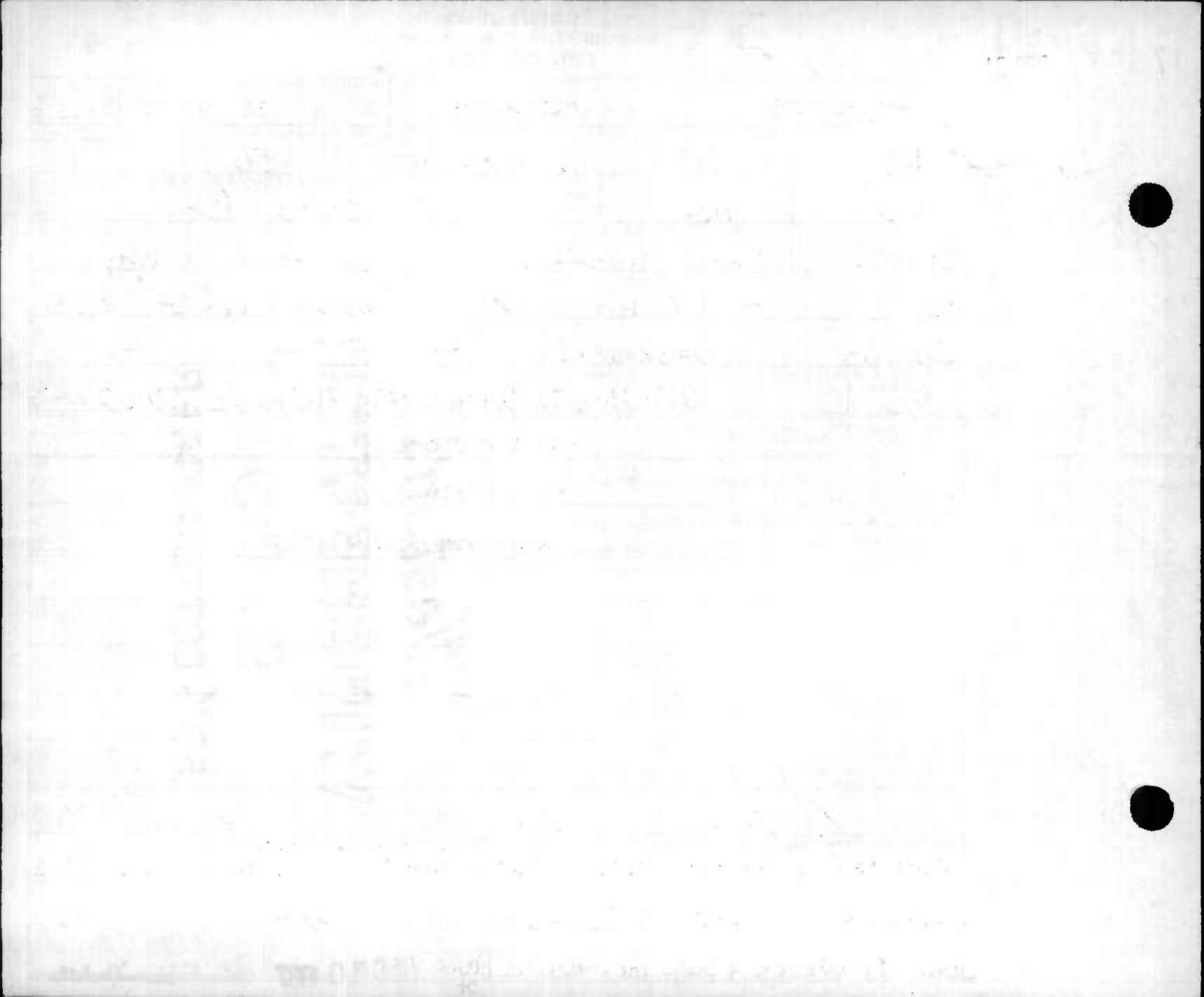
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34559
REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ronald Dabkowski | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 24 87 | | 2b. HOUR
P M
6:25 P |
| 3. SEX
M | 4. RACE
W I | 5. DATE OF BIRTH
MONTH DAY YEAR
2 - 15 - 1937 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
50 YRS. | IF UNDER 1 YEAR
IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sanitation | 12b. KIND OF BUSINESS OR INDUSTRY
City | |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
Balto | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2200 Fleet St. 21231 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Julius Dabkowski | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
— — — | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
219-26-682 | | 17. INFORMANT
ADDRESS
WALTER Michael Kiewicz 2200 Fleet St | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic Shock
DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) Gastrointestinal Bleed | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | 22c. DATE SIGNED
12/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jonathan D. Kushner, M.D. | | 22e. ADDRESS
Church Hospital
100 N. Broadway, Baltimore, Md. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
12-26-87 | 23c. NAME OF CEMETERY OR CREMATORY
Westview MEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto MD | |
| 24. FUNERAL DIRECTOR
NAME
John M. Weber & Sons Inc. | | ADDRESS
4015. Chester | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 5 5 8
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|--|
| DECEASED NAME
(TYPE OR PRINT)
FIRST <i>Eva</i> MIDDLE <i>Agnes</i> LAST <i>Czyzia</i> | | 2a. DATE OF DEATH
MONTH <i>December</i> DAY <i>5</i> YEAR <i>1987</i> | | 2b. HOUR <i>5:35</i> P. <i>M.</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH <i>12</i> DAY <i>18</i> YEAR <i>03</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>412 Cornwall Street</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 12a. USUAL OCCUPATION
(TYPE WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Housework</i> | | | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | |
| 14. FATHER'S NAME
FIRST <i>Lawrence</i> MIDDLE <i>Szczepaniak</i> LAST <i>Agnes</i> | | 15. MOTHER'S MAIDEN NAME
FIRST <i>Agnes</i> MIDDLE <i>Spochacz</i> LAST <i>Spochacz</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>215-03-1871</i> | | 17. INFORMANT
ADDRESS
<i>Leona Campbell 412 Cornwall Street</i> | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Sacral Decubiti</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Diabetes mellitus</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Alzheimer</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/29/86</i> 19 <i>86</i> , to <i>11/18/87</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>12/5/87</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Simon</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12-7-87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Simon V. Simon</i> | | 22e. ADDRESS
<i>2900 E. Baltimore St. 21224</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12-09-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Saint Stanislaus</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore City Md.</i> | | 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Charles S. Zeiler & Son Inc. 6224 Eastern Ave.</i> | | | |
| 25a. DATE REC'D. BY REGISTRAR
<i>DEC-9 1987</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Gordon-Rendell</i> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

December 2, 1947

2

13.1

21

5

202

• • •

David M. Hanson

218

၁၄၈၂

32

2512 2011-01-01

Answers 2

1351

2005002

158-0-715

7-9-21

075204 DEC 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

34560
REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ROBERT JOHN DAHLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 10, 1987 | | 2b. HOUR
9:38 M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
12 01 1987 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS 10 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
--- | | 12b. KIND OF BUSINESS OR INDUSTRY
--- |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE --- GLODE III | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DEBORAH --- FISHPAUGH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
n/a | | 17. INFORMANT
ADDRESS
RICHARD FISHPAUGH 1229 HESSE AVE 21237 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>congenital heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 min.</u>
<u>9 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December 2, 19 87</u> , to <u>December 10, 19 87</u> , that (I) <u>(we)</u> lost
saw the deceased alive on <u>December 10, 19 87</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated
above, (I) <u>(we)</u> did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Susan E. Coffin MD</u> | | DEGREE
MD | | 22c. DATE SIGNED
<u>12/10/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>SUSAN COFFIN</u> | | 22e. ADDRESS
<u>600 N. WOLFE ST. BALTO., MD.</u>
<u>JOHNS HOPKINS HOSPITAL 21205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
<u>12/12/87</u> | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO BALTO MD | |
| 24. FUNERAL DIRECTOR
NAME
<u>[Signature]</u> | | ADDRESS
<u>nachreape</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 13 1987</u> | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

MEDICAL CERTIFICATION

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

01320 01320

PO BOX 111111

111111

111111

111111

01320 01320

077431 JAN-78

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 4561

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EUFROZIMA DAILIDAVICIUS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 25, 1987 | | | 2b. HOUR
M | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 18, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Lithuania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Haven Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Woodstock | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10114 Old Court Rd. 21163 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-30-8720 | | | 17. INFORMANT Social Worker ADDRESS
Mary Guy, Investment Bldg. Towson, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) C.O.P.D.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION
11-27-87 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
10-24-87 | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-24-87 to Dec 18 1987 , that (I) (we) lost
saw the deceased alive on 11-27-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME
Jorge H. Ordonez, M.D. | | | | | | 22e. ADDRESS
2601 E. Monument St. Baltimore, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Jan. 4, 1988 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | | 23d. LOCATION
Dundalk, Balto. Co. Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balt., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1988 | | 25b. REGISTRAR'S SIGNATURE
 | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 2 to the funeral director. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

077431-21-500

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

10-19-87

1

01-23-10 01-23-10

RECEIVED

NOTION 2/03

INDIA



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 4 5 6 3

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------------|--|--|--|--|--|---|--|--|--|--|--|--------------------------------------|--|-----------------------------|--|--|--|--|--|--|--|
| 1. LAST NAME
(TYPE OR PRINT) (BABY) MARK | | | | | | 2. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 15 87 | | | | | | 3b HOUR AM PM | | | | | | | | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 9 30 87 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 2 | | 7. IF UNDER 1 YR. MONTHS DAYS 15 | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 15 87 | | 7d HOUR AM PM Noon | | | | | | | | | | | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 8b. CITIZEN OF WHAT COUNTRY? USA | | | | 8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA | | | | 12b. KIND OF BUSINESS OR INDUSTRY NA | | | | | | | | | |
| 13a. STATE MD | | | | | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2426 CALLOW AVENUE 21217 | | | |
| 14. FATHER'S NAME FIRST MARK MIDDLE EUGENE LAST DALTON SR. | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST TOWANDA MIDDLE HARVEY LAST | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | 16b. SOCIAL SECURITY NO. NA | | | | 17. INFORMANT ADDRESS ACQUINETTE JOHNSON 2426 CALLOW AVENUE | | | | | | | | | | | | | |

| | |
|---|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | |
| <div> <div> 9130 </div> <div> IMMEDIATE CAUSE (a) <u>Asphyxia</u>
 DUE TO, OR AS A CONSEQUENCE OF </div> </div> | |
| <div> <div> Conditions, if any, which
 gave rise to immediate
 cause (a) stating the <u>under-</u>
 <u>lying cause lost.</u> </div> <div> (b) _____
 DUE TO, OR AS A CONSEQUENCE OF </div> </div> | |
| <div> <div></div> <div> (c) _____
 DUE TO, OR AS A CONSEQUENCE OF </div> </div> | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

| | | | | | | |
|-----------------------|---|--|---|--|--|--|
| MEDICAL CERTIFICATION | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 12-13-1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject wedged between mattress and crib rail | |
| | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1415 Demarcay Way, Balto. MD | |

22a I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [Signature] M.D. Deputy Chief TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED 12-16-87

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., MD 21201

| | | | | | | |
|---|--|------------------------------|--|---|---------------------|--------------------|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/19/87 | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW CEMETERY | 23d. LOCATION
CITY OR TOWN
DUNDALK CO., | COUNTY
MD | STATE
MD |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H INC. | | | | 25a. DATE REC'D BY REGISTRAR
DEC 18 1987 | | |
| ADDRESS
1101 E. NORTH AVE | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson Hendell</i> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL—TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PEBBLE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

DHMH - 17
(VR A15 ME (5))

100% COTTON FIBER

WATER-RESISTANT

[Handwritten signature]



077010 JAN

1558
FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 4564

| | | | | | | | | |
|--|--|---|---|---|------------------------------------|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Elliot I. DANIEL | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-28-87 | | 2b. HOUR
8:45 AM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
3 21 46 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.
41 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sina Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ATTORNEY | | 12b. KIND OF BUSINESS OR INDUSTRY
US DEPT. LABOR | | |
| 13a. STATE
MD. | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
NOAH DANIEL | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MURIEL GORAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
069-38-7378 | | 17. INFORMANT
MRS. ROSALIE DANIEL | | 17b. ADDRESS
6901 GREENSPRING AVE. BALTO., MD 21209 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute MI
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
acute | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 81 to 12/28/87 19 87 , that (we) lost saw the deceased alive on Dec 20 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | |
| 22b. SIGNATURE
Leon G. Sheek, MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12/28/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEON G. SHEEK, MD | | | | 22e. ADDRESS
6715 PARK HEIGHTS AVE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
DEC. 29, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
CHEVRA AHAVAS CHESD | | 23d. LOCATION CITY OR TOWN COUNTY STATE
RANDALLSTOWN BALTO. MD | | |
| 24. FUNERAL DIRECTOR NAME
SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP _____

18-25-01

18-25-01

18-25-01

14

14

14

14

14

18-25-01

18-25-01

18-25-01

18-25-01

18-25-01

074201 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified orally.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
NICHOLAS DANTONI | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 1 87 | | | | | 2b. HOUR
1330 M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 22 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
FOREMAN-WATER DEPT. | | 12b. KIND OF BUSINESS OR INDUSTRY
BALTO. CITY | | | |
| 13a. STATE
MD. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4246 SEIDEL AVE. 21206 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
SALVATORE DANTONI | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANGELINA MESSINA | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-18-6463 | | 17. INFORMANT ADDRESS
VITA DANTONI (WIFE) SAME ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarct failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
chronic renal insufficiency, cerebrovascular disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Patrice W. Miller</i> | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
12/1/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PATRICE W. MILLER M.D. | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION
BALTIMORE | | COUNTY
MD. | | | |
| 24. FUNERAL HOME
SCHMIDT FUNERAL HOME, INC. | | 3331 Brehms Lane
Balto. Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR
DEC - 4 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |

031-001 000-761

THE UNIVERSITY OF CHICAGO
LIBRARY

4
3
2
1
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

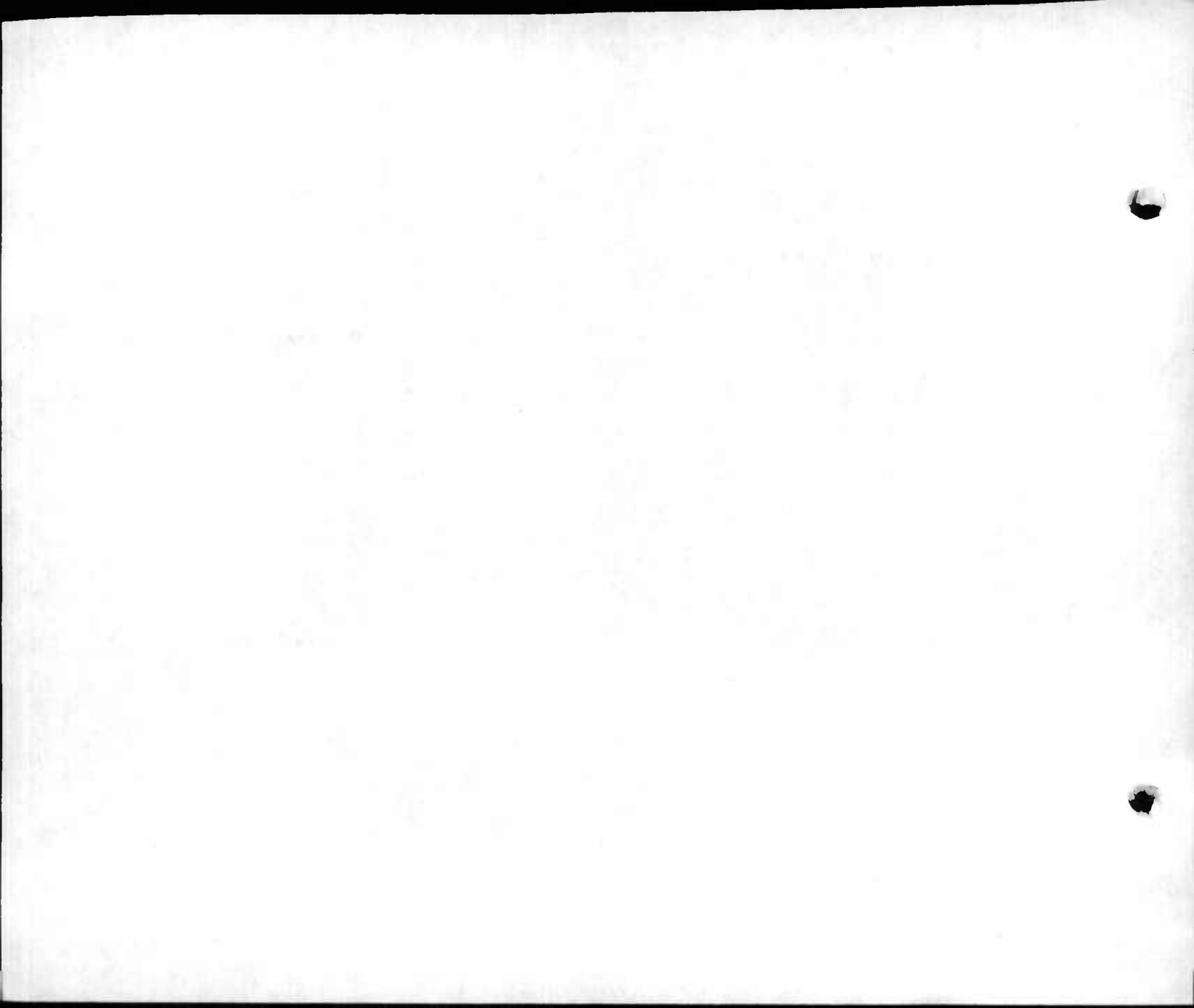
RECEIVED JAN 1 1961

X

DEC - 4 1961

VOID

CERTIFICATE # 34566



076687 DEC 29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 7 3 4 5 6 7

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|--|-----------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DOROTHY Dill DAVIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 - 29 - 1987 | | 2b. HOUR
5:25 A.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 9, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belair Convalesarium 21206 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept Store | |
| 13a. STATE
Maryland | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Belair | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Dill | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Faustina Woods | | 16. STREET ADDRESS / ZIP CODE
1413 Gunston Road 21014 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
212-34-4899 | | 17. INFORMANT
ADDRESS Belair, MD.
Betty Sumner 1413 Gunston Road Belair, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) SICK SINUS SYNDROME
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) SEVERE CORONARY ART.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) DISEASE, CHF, DEMENTIA | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 06-15-1984, 19, to 12-29-87, 19, that (1) (we) last saw the deceased alive on 12-28-87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE | | 22c. DATE SIGNED
12/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LUIS E. RIVERA | | | | 22e. ADDRESS
5714 Harford Road
Baltimore, Maryland 21214 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec 31, 87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
DIPPEL FUNERAL HOME, INC.
7110 Belair Road Baltimore, MD 21206 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

[illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 3 4 5 6 8

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|---|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELEANOR DAVIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC. 21, 1987 | | 2b. HOUR
8:50 AM | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG. 31 1917 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
75
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LEVIN JANE HEBERSON GERIATRIC HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-22-7566 | |
| 17. INFORMANT
NAME ADDRESS
James Davis 4214 Park Heights Ave | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE INTRACEREBRAL HEMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
< 2 MONTHS | | PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 12/21/87 to 12/21/87 , that (we) last saw the deceased alive on 12/21/87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. | | 22b. SIGNATURE
E. O. K. M. M.D. | | 22c. DATE SIGNED
12/21/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ESTRELLITA O. K. M. M.D. | | 22e. ADDRESS
LEVIN JANE HEBERSON GERIATRIC HOSPITAL | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/24/87 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co Md | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H West 4300 Wabash Avenue | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1987 | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07023-0202

DEC 30 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove exonerators. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|-------------------------|---|--|---|--|
| DECEASED NAME
(TYPE OR PRINT) EVELYN DAVIS | | 2a. DATE OF DEATH
MONTH 12 DAY 18 YEAR 87 | | 2b. HOUR
4:40 ^P | |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH 03 DAY 01 YEAR 20 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
US. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LIBERTY MED. CENTER | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE Rogers LAST Rogers | | 15. MOTHER'S MAIDEN NAME
FIRST Francis MIDDLE Miller LAST Miller | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Chart | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ANOXIC ENCEPHALOPATHY
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) COPD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHF | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/15 , 19 87 to 12/18 , 19 87 , that (I) (we) last saw the deceased alive on 12/18 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Amba Woreta MD | | DEGREE
MD | | 22c. DATE SIGNED
12/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AMBACHEN WORETA | | 22e. ADDRESS
LIBERTY MEDICAL CENTER | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus MEM. | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Maryland | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
E.L. Phillips Fun. | | ADDRESS
1721-27 N. Monaca St. | | DATE RECEIVED BY REGISTRAR
DEC 21 1987 | |
| 25. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

1953

1953

1953

1953

1953

1953

1953

1953



1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34570

1- STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

THURMAN L DAVIS

2a DATE OF DEATH MONTH DAY YEAR 12/4/87 2b HOUR 5:43 P.M.

3 SEX

M

4 RACE

W

5 DATE OF BIRTH

MONTH DAY YEAR 2 5 16

6 AGE (IN YEARS LAST BIRTHDAY)

71 YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Blt City MD

10 CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Francis Scott Key Inc

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Beth Steel

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE Maryland

13b COUNTY Baltimore

13c CITY OR TOWN Dundalk

13d INSIDE CITY LIMITS? YES ☐ NO ☒ XX

13e STREET ADDRESS / ZIP CODE

1904 Jasmine Rd. 21222

FATHER'S NAME

Charles

MIDDLE

Davis

LAST

15 MOTHER'S MAIDEN NAME

Mildred

MIDDLE

Meyers

LAST

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

W.W.II

212-03-8637

17 INFORMANT

Bessie E. Davis Same as 13e

ADDRESS

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

25 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) myocardial infarction; ^{coronary} ~~coronary~~

DUE TO, OR AS A CONSEQUENCE OF

(c)

25 Days Death

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Chronic Obstructive Pulmonary Disease, old

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from Dec 1, 19 87, to Dec 4, 19 87, that (I) (we) last saw the deceased alive on Dec 4, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

Robert Study

DEGREE

MD PhD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c DATE SIGNED

12/4/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Robert Study

22e ADDRESS

Francis Scott Key Inc Baltimore, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

12-7-87

23c NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

23d LOCATION CITY OR TOWN

Baltimore Maryland

24 FUNERAL DIRECTOR

Duda-Ruck, Inc. 7922 Wise Ave Dundalk, Md

21222

25a DATE OF DEATH BY REGISTRAR'S SIGNATURE

DEC 08 1987 John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, named cause of death must be noted on page 3.

071 170 170-801

98812 NOTION 202

DAVID

WINTERFIELD



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

4571

FOR
1. STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LAWRENCE E. DAWSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/25/87 | | 2b. HOUR
10 ⁵² AM |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
03 23 43 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
B. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
U.M.M.S. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Construction Worker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
B. MD | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
407 FREEMAN ST 21225 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HERBERT DAWSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GARNET MCGEE | | ADDRESS
78 main st. Box 325 Smithfield PA 15787 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
162-34-5894 | | 17. INFORMANT
Brownfield Funeral Home | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>METASTATIC OROPHARYNGEAL CANCER</u> 2 ⁺ yrs.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>HYPERCALCEMIA</u> 2 ⁺ months | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>NONE</u> | | | | | |
| 19a. DATE OF OPERATION
1985 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
OROPHARYNGEAL CANCER | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC. 24</u> 19 <u>87</u> , to <u>DEC 25</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>DEC 25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Bruce L. Feldman</i> | | DEGREE
MD | | 22c. DATE SIGNED
12/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRUCE L. FELDMAN | | 22e. ADDRESS
DEPT MED, UMMS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-24-87 | 23c. NAME OF CEMETERY OR CREMATORY
ODD FELLOWS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SMITHFIELD FAYETTE PA. |
| 24. FUNERAL DIRECTOR
NAME
JOHN BROWNFIELD | | ADDRESS
SMITHFIELD, PA | | DATE REC'D. BY REGISTRAR
DEC 30 1987 | |

MEDICAL CERTIFICATION

10-11-33

01

RECEIVED

DEC 30 1933

DEC 30 1933

076970 JAN -5 88

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 4572

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Lillian Day | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-21-87 | | 2b. HOUR
3:15 PM | | | | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
01-10-10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 yrs
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)
Va | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2712 W. Fairmount Avenue | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN, INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
2712 W. Fairmount Ave 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Sorrell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Garner | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
222-20-8456 | | 17. INFORMANT ADDRESS
Martha Miller 2712 W. Fairmount Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Cancer of ovary</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-12</u> , 19 <u>87</u> , to <u>12-21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Sireesh Tripurawani | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SIREESH TRIPURAWANI | | | | 22e. ADDRESS
BON SECOURS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1988 | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

074949 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|---|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | MIDDLE | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR | |
| ROBERT | | HOSLEY | | DEAN | | 12 - 12 - 87 | | 309 A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| MALE | WHITE | 2 26 09 | | 78 YRS. | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | SOUTH BALTIMORE GENL HOSP. | | | SIGN PAINTER | | STATE | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | A.A. | | BROOKLYN PK. | | | | 21225 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | |
| ROBERT FORD DEAN | | LEILA MAE JOY | | 16b. SOCIAL SECURITY NO. 217-01-2925 | | | | | |
| 16c. NO | | 17. INFORMANT ADDRESS 21225 | | | | | | | |
| | | MARIAN DEAN 206 E. HILLCREST AVE. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF -
(b) <u>CARDIOVASCULAR (Kidney)</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2 years</u> , 19 <u>87</u> , to <u>1987</u> , that (I) (we) last saw the deceased alive on <u>2 weeks</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Moises Fraiman</u> | | | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12-14-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>MOISES FRAIMAN</u> | | | | 22e. ADDRESS
<u>South Baltimore General Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 12/15/87 | | Meadowridge Mem. pk. | | Elkridge Howard Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 21229 | | DEC 14 1987 | | | |

0140000000

AM 1000000000

0000000000

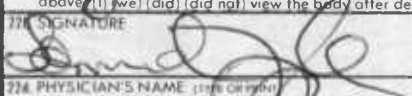
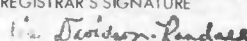
0000000000

074682 DEC 10 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|---|--|--------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Robert O. DeCamp | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-07-87 | | 2b. HOUR
4:30P M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 16 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2828 Huntingdon Ave. 21211 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Beer Distrib. | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph DeCamp | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Waterman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
ADDRESS
Mary J. DeCamp 2828 Huntingdon Ave. 21211 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA, LUNG</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 MONTHS</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 10</u> 19 <u>87</u> , to <u>DECEMBER 7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>NOVEMBER 2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | DEGREE
MD | | | 22c. DATE SIGNED
12/8/87 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Samuel Zyglar | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co., Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Burgee-Henss Funeral Home | | | | ADDRESS
3651 Falls Rd. 21211 | | 25a. DATE REC'D. BY REGISTRAR
DEC - 9 1987 | | 25b. REGISTRAR'S SIGNATURE
 | | |

10 01 920 SH0450

BP

DHMH-16 50M (1/81)
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34575

| | | | | | | | | | | | |
|---|--|--|--|---|---------------|---|---|--|-------------------|--|--|
| FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Sarah | MIDDLE
NMI | LAST
DEES | 2a. DATE OF DEATH
MONTH DAY YEAR
12 18 87 | | 2b. HOUR
3 P M | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 7 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV of MD HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1010 W. Balt St # 504 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tom JONES | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AILEEN FERGUSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-22-1656 | | 17. INFORMANT ADDRESS
Vera Hall 2318 Winder Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DOE TO, OR AS A CONSEQUENCE OF (b) METASTATIC Sq Cell Lung Cancer
DOE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Post obstructive pneumonia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 12/14 19 87 to 12/18 19 87, that (1) (we) lost saw the deceased alive on 12/18 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Glenn D. Gilmor | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Glenn D. Gilmor | | | | 22e. ADDRESS
22 S. Greene St Univ of MD Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/22/87 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | 25. DATE REC'D. BY REGISTRAR
DEC 22 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

103

103



075603 DEC 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34576

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Marie DeLoach. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 15 1987 | | | 2b. HOUR
1:40 PM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 17 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY HOSPITAL BUREAU | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
LUNDAL | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
101 CENTER PLACE 21202 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN WATTEYSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CLARA COLLINS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-05-2678 | | 17. INFORMANT ADDRESS
MARGARET JENNING 2224 E OLIVER ST | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) CVA | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
CVA | | | | | | | | | |
| 19a. DATE OF OPERATION
12/1/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
② Knee replacement - DJD | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 4 , 19 87 , to Dec 15 , 19 87 , that (I) (we) last saw the deceased alive on Dec 15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
William Tse MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/15/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William Tse | | 22e. ADDRESS
4980 Eastern Ave, Baltimore MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12-19-87 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto MD 21234 | | | |
| 24. FUNERAL DIRECTOR
NAME
James Amato & Sons | | ADDRESS
1701 Laurel Ball St | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randner | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

074928 DEC 14 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BERTHA DEMBECK | | | | | | | | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH
MONTH 2 DAY 19 YEAR 06 | | 6. DATE OF DEATH
MONTH 12 DAY 9 YEAR 87 | | 7. HOUR 3:15 P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD USA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY | | | | MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SOTT KEY | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 518 S. KENWOOD AVE 21224 | | | |
| 14. FATHER'S NAME
FIRST BENJAMIN MIDDLE BRONAKOWSKI LAST LILIAN | | 15. MOTHER'S MAIDEN NAME
FIRST LILIAN MIDDLE LANOCHA LAST LANOCHA | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-09-1642 | | 17. INFORMANT ANTHONY DEMBECK | | ADDRESS 518 S. KENWOOD AVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA VS. ARDS
DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE SEPSIS | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METASTATIC CANCER | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9 19 87 , to 12/9 19 87 , (that (I) (we) lost | | saw the deceased alive on 12/9 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE M. Cloeren | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/9/87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. CLOEREN | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE BALTO COUNTY MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME JOHN M. WEBER & SONS INC | | ADDRESS 401 S CHESTER ST | | 25a. DATE REC'D. BY REGISTRAR DEC 11 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | | | | |

BP

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to discern but appear to include:]

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to discern but appear to include:]

075104 DEC 15 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 5 7 8
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ESTORIA | | DEMPSEY | | DECEMBER 8, 1987 | | 5:56P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| FEMALE | BLACK | 4 27 10 | | 77 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| NC | USA | | | BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | | CUSTIAN | | N/A | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. COUNTY | | | |
| 13a. STATE MD | | | | 13b. COUNTY BALTIMORE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13c. CITY OR TOWN | | | |
| UNKNOWN | | UNKNOWN | | BALTIMORE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | 216-09-0376A | | APT. G MAE MORGAN 602 CHERRY CREST ROAD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Progressive Acidemia</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 weeks</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Metabolic Acidosis</u> | | | | | | | <u>3 weeks</u> |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dysphagia, Renal Failure</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> , 19 <u>87</u> , to <u>12/8</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/8</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>Neil R. Powe</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | <u>12/8/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| <u>Neil R. Powe</u> | | <u>JH H 600 N. Wolfe St Baltimore MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 12/15/87 | | BALTIMORE CEMETERY | | BALTIMORE MD | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | DEC 14 1987 | | <u>Julia Davidson-Randall</u> | |

BP

0231001250

0231001250

076665 DEC 31 1987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH37 3 4 5 7 9
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Emmons De Vaughn | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 23 87 | | 2b. HOUR
0122AM | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 07 21 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore (City) - MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lach Raven VA Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Parking ATTENDANT | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE
MD | | 13b. COUNTY | |
| 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1825 Chilton Street - 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles De Vaughn | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eva Scott | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | |
| 16b. SOCIAL SECURITY NO.
577-24-8289 | | 17. INFORMANT
ADDRESS
Vaughn De Vaughn 1825 Chilton ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Possible Pulmonary Embolus or Aspiration
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 12-17 - 19 87 , to 12-23 - 19 87 , that (I) (we) lost
saw the deceased alive on 12-23 - 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Jeffrey Joe, MD | | DEGREE
MD | | 22c. DATE SIGNED
12-23-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey Joe, MD | | 22e. ADDRESS
22 S. Greene St. Baltimore, MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST VET | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWING'S MILLS MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | |
| 25b. REGISTRAR'S SIGNATURE
John Swickard-Randall | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

DHMH - 16 50M 1/81
(VRA 15, 4)

075803

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon pages: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8734580

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR
- STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR
DEC. 13, 1987 | | 2b. HOUR
4:50 A M | |
| 1. DECEASED NAME (PRINT)
MARC Russell DEVINSKY | | 3. SEX
Male | | 4. RACE
White | |
| 5. DATE OF BIRTH
May 14, 1985 YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
2 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 11. CITY OR TOWN OF DEATH
BALTIMORE | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 13. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul Devinsky | | 15. MOTHER'S MAIDEN NAME
MIDDLE
Mdry Ellen Signorille | | 16. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 18. SOCIAL SECURITY NO.
219-08-4856 | | 19. INFORMANT
Bruce J. Lipstein | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Sepsis, Septic Shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Immunosuppressed Pt. w/ Liver Transplant</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>24</u>
<u>48</u>
<u>one week</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Ischemic (R) heart extremely Transplanted</u> | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/13/87</u> 19 <u>87</u> to <u>12/13/87</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12/13/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Paul Redwood</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/13/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Redwood</u> | | 22e. ADDRESS
<u>600 N. WOLFE ST 21205</u>
<u>JAH</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>12/14/1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>King David Mem. Garden</u> | |
| 23d. LOCATION
(IF NOT TOWN)
<u>Falls Church, Virginia</u> | | 23e. NAME OF CEMETERY OR CREMATORY
<u>King David Mem. Garden</u> | | 23f. LOCATION
(IF NOT TOWN)
<u>Falls Church, Virginia</u> | |
| 24. FUNERAL DIRECTOR
<u>STEIN HEBREW MEMORIAL FUNERAL HOME</u>
<u>232 CARROLL STREET, N. W., WASHINGTON, D. C.</u> | | 25. DATE REC'D BY REGISTRAR
<u>DEC 16 1987</u>
<u>Julia Stein</u> | | | |

BP

012003 IN 20

3214 100114 2001

001 1 2001

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

074508 DEC 8 1987

37 34581

| | | | | | | | | | | |
|--|--|--|--|--|---|--|--------------------------------|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
David Nathan Dickson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 6, 1987 | | | 2b. HOUR
5:03 PM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 3, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Watch Maker | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Weller Lee Dickson | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Phronie Peek | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
NA | | 17. INFORMANT (Nephew)
James L. Martin | | ADDRESS 3748 Jenifer NW
Washington, DC 20015 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Severe Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic Adeno. CA of Lung with</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pleural effusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>11-17-</u> 19 <u>87</u> to <u>12-06-</u> 19 <u>87</u> , that (we) lost
saw the deceased alive on <u>12-06-</u> 19 <u>87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated
above. (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Amadeo</u> | | | | | DEGREE
MD | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Amadeo |
| 22e. ADDRESS
South Baltimore General Hospital | | | | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT)
Amadeo | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec 8, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A A Co. Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | | | | ADDRESS
Glen Burnie, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
DEC - 8 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Richard L. ...</u> | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

07-208 DEC-31

FROM FILE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|----------------------------------|--|----------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. DATE OF DEATH | | 7. HOUR | |
| EDNA | | Belle | | DIEHL | | F | | Cauc | | 8 MONTH 13 DAY 1904 | | DECEMBER 19, 1987 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 11. KIND OF BUSINESS OR INDUSTRY | | 12. HOURS | |
| N.C. | | USA | | | | Baltimore City | | Homemaker | | own home | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | 13f. ZIP CODE | | | |
| Md | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8031 Balto St | | 21224 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17a. ADDRESS | | | |
| E. Emm | | Brackett | | Unknown | | No | | 213-30-4653 | | Mrs. Phyllis Odom | | 8031 Balto St. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) XXXXL ADULT RESPIRATORY DISTRESS SYNDROME
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF BRONCHOPNEUMONIA
(c) DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: STAPH SEPSIS | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV. 20, 19 87, to DEC. 19, 19 87, that (I) (we) last saw the deceased alive on DEC. 19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | |
| Zachary J. Hodes, MD | | | | 12/19/87 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | | | | | | | |
| ZACHARY HODES | | CHURCH HOSPITAL CORP | | DEC 21 1987 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | 12/23/87 | | Balto National Cem | | Balto | | Balto | | Md. | | | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | | | | | |
| John A. Moran, Inc. | | 3000 E. Balto St | | 21224 | | DEC 21 1987 | | | | | | | |

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 5 8 3
REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Frank Joseph Dieso, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 8, 1987 | | | 2b. HOUR
1150 P M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 2, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Seaton Hill Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ship Super. | | 12b. KIND OF BUSINESS OR INDUSTRY
Md. Dry Dock | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
133 Louise Terrace, 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Dieso Concetta Aquista | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Aquista | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
Korean | | 17. INFORMANT (Wife)
Norma B. Dieso | | ADDRESS
Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Aspiration Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 min.</u>
<u>15 min.</u> | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Senile Alzheimer's Disease; Malnutrition</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-8</u> 19 <u>87</u> to <u>12-8</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12-8</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Jammi Punzalan</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12/10/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>J. Punzalan M.D.</u> | | | | 22e. ADDRESS
<u>5214 Haywood Rd. Balt. Md</u> 21233 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
<u>Dec. 12, 1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Brooklyn Pk. A.A. Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>Singleton Funeral Home, Glen Burnie, Maryland</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 11 1987</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Borden-Rodwell</u> | | | |

BP

UNITED STATES

20% COTTON



1/4

Handwritten signature or scribble at the bottom of the page.

076736 DEC 31 1987

244

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at page 3.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR | |
| | | JAMES BURGESS DIGGS JR. | | | | December 29, 1987 | | 6:32 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | White | | Feb. 25, 1930 | | 57 | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD | | USA | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 5705 Stony Run Drive | | | | Engineer - Westinghouse | | Westinghouse | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| MD | | | | Balto. | | | | 5705 Stony Run Dr., 21210 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| James Burgess Diggs | | | | Rosalie Berry Tubman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes | | Korean | | 218 28 5378 | | Sally Diggs, Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic AdenoCA-GI</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 Mo</u>
<u>6 Mo</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>-</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9/16/87</u> to <u>12/29/87</u> , that (I) (we) last saw the deceased alive on <u>12/29/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Gregory L. Walker</u> | | | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/30/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Gregory L. Walker, MD | | | | 22e. ADDRESS
3300 N. Calvert St., Balto., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Cremation | | 12/30/87 | | Green Mount | | Balto., MD | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| H. W. Jenkins & Son sCo. | | | | DEC 30 1987 | | <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

29

BP

1. Summary

2. Description of the problem

3. Analysis

4. Recommendations

075497 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FPM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. 4 5 8 5

| | | | | | | | |
|---|-----------------------------|---|-------------------|---|--|---|--|
| 1- STATE REGISTRAR | | 2a DATE KNOWN OF DEATH | | 3 MONTH DAY YEAR | | 4 HOUR | |
| BASED NAME (TYPE OR PRINT) | | MELVIN | | DIGGS | | 12-14-87 | |
| 3. SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 7d. HOUR |
| male | black | 5 27 1920 | 67 YRS. | | | 12-14-1987 | 6:32 PM |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md | U S A | | WIDOWED | | Baltimore City MD | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| Baltimore | | Sinai Hospital | | | Self Employed | | |
| 13a STATE | | 13b COUNTY | 13c CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e STREET ADDRESS | | |
| Md | | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Cedardale 21215 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Joseph | | Louise | | Diggs | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Yes | | 218-01-4372 | | Margaret Scott 3115 Leighton Avenue | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| AT WORK | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | |
| Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | |
| Charles P. Kokes | | Assistant | | 12-15-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | |
| Charles P. Kokes, M.D. | | 111 Penn Street, Baltimore, MD 21201 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| Burial | 12/21/87 | Garrison Forest Vet | | Owings Mills | | Md | |
| 24 FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H West 4300 Wabash Avenue | | DEC 17 1987 | | | | | |

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

1961 JUN 10 10:00 AM

RECEIVED MOTOR CO

WINDY
MAY 11 1961



1961 JUN 10

075122 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| FLORANCE | | DI PIETRO | | DECEMBER 12, 1987 | | 2:04am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. | |
| FEMALE | | WHITE | | SEPT. 3 1912 | | 75 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| ITALY | | ITALY | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | CHURCH HOSPITAL CORPORATION | | NONE | | - | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS / ZIP CODE | |
| MD. | | - | | BALTIMORE | | 225 ALBEMARLE ST. 21202 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| THOMAS | | DI PIETRO | | JULIA | | DI PENTIMA | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| ROSE DI PIETRO | | HYPOXEMIC RESPIRATORY FAILURE | | DECEMBER 6, 1987 | | DECEMBER 12, 1987 | |
| 1711 RAMBLEWOOD RD. 21239 | | PNEUMONITIS | | 19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21. LOCATION CITY OR TOWN COUNTY STATE | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21e. DATE OF OPERATION | | 21f. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21h. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21j. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21k. DATE OF OPERATION | | 21l. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21m. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21n. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21o. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21p. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21q. DATE OF OPERATION | | 21r. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21s. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21t. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21u. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21v. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21w. DATE OF OPERATION | | 21x. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21y. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21z. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21aa. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21ab. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21ac. DATE OF OPERATION | | 21ad. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21ae. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21af. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21ag. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21ah. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21ai. DATE OF OPERATION | | 21aj. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21ak. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21al. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21am. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21an. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21ao. DATE OF OPERATION | | 21ap. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21aq. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21ar. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21as. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21at. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21au. DATE OF OPERATION | | 21av. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21aw. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21ax. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21ay. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21az. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21ba. DATE OF OPERATION | | 21bb. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bc. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bd. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21be. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bf. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bg. DATE OF OPERATION | | 21bh. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bi. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bj. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bk. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bl. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bm. DATE OF OPERATION | | 21bn. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bo. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bp. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bq. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21br. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bs. DATE OF OPERATION | | 21bt. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21bx. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| | | | | 21bw. DATE OF OPERATION | | 21bx. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 21bu. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21bv. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | | | 21bw. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |

CHURCH, JOHN STELLA

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

100-381370

DEC 18 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34587
REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELIZABETH AGNES DITTMAR | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 11, 1987 | | 2b. HOUR
4:45A M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
February 2, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Meridian Long Green | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Receptionist | | 12b. KIND OF BUSINESS OR INDUSTRY
Medical |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Towson | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael John Joseph Dougherty | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary McAuliffe | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-01-8286 | | 17. INFORMANT
ADDRESS
Wm. Dittmar 903 Southerly Road 21204 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Bronchiectasis, Chronic</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>years</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Alzheimer's disease, Severe Osteoporosis, Compression Fracture spine</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<u>Maryland</u>
CERTIFICATION APPROVED BY MEDICAL EXAMINER | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>May 23</u> , 19 <u>86</u> , to <u>December 11</u> , 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>December 10</u> , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Shirley Hoot</u> | | DEGREE
MD | | 22c. DATE SIGNED
12/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Cool-Foley | | 22e. ADDRESS
201 East University Pkwy 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-14-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home 6500 York Road 21212 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John F. Anderson</u> | |

172156 031207

031207 172156

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

172156 031207
[Illegible text at the bottom of the page, including a date stamp.]

074609 DEC 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34588

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|---|--|--|---|--|
| 2 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Roger Dewey Dixon | | | 2a DATE OF DEATH
MONTH DAY YEAR
12/6/87 | | 2b HOUR
9:50 AM |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 16 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret'd Clarks Welding & Machine | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (# NURSING HOME OR OTHER INSTITUTION: GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
Maryland Baltimore Baltimore | | 13b INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13c STREET ADDRESS / ZIP CODE
232 Oakwood Road 21222 | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Telos Dixon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Anna Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
244-16-1670 | 17 INFORMANT ADDRESS
Goldie M. Dixon 232 Oakwood Road 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/5 , 19 87 , to 12/6 , 19 87 , that (I) (we) last saw the deceased alive on 12/6 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Grace A. Coedts MD | | DEGREE | | 22c. DATE SIGNED
12/6/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GRACE A. COEDTS MD | | 22e. ADDRESS
FSKme Baltimore, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12-9-87 | 23c. NAME OF CEMETERY OR CREMATORY
Bel Air | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bel Air, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck Funeral Home of Dundalk | | ADDRESS
7922 Wise Ave. Dundalk, MD 21222 | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1987 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

BP

074002 DEC 10 87

Robert J. Dixon 12/10/87

A-1c White 12/10/87

Bottomed (Knox) 12/10/87

12/10/87

DAVID DINE

NO. 1 COTTON 1984

DEC 9 1987

076752 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbanpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked ar, item 18 shows any injury, or other traumatic events, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34589

| | | | | | | |
|--|--|--|--|---|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MELVIN GEORGE DOERING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 29, 1987 | | 2b. HOUR
12 ¹⁵ P.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 7 1912 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SUPERINTENDENT | | | 12b. KIND OF BUSINESS OR INDUSTRY
PURITAN-BENNETT | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GOERGE DOERING | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
ELIZABETH BORGMAN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-03-5589 | | 17. INFORMANT
ADDRESS
HELEN DOERING (WIFE) SAME ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST / EMD</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PRESUMED CORONARY ARTERY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>COPD & ATRIAL FIBRILLATION</u> | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
N/A | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC. 21</u> 19 <u>87</u> to <u>DEC. 29</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>DEC. 29</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Ann A. Tran, MD</u> | | | | 22c. DATE SIGNED
<u>Dec. 29, 1987</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANN TRAN, M.D. | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/31/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MORELAND MEM. PARK | | |
| 23d. LOCATION
(CITY OR TOWN)
BALTIMORE | | 23e. COUNTY
MD. STATE | | | | |
| 24. FUNERAL DIRECTOR
SCHLUNKER FUNERAL HOME, INC. | | 3331 Brehms Lane
Balto. Md. 21213 | | DEC 30 1987 | | |

074521 DEC - 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 3 4 5 9 0
REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Daniel | | FIRST Daniel MIDDLE Doherty LAST Doherty | | 2a. DATE OF DEATH MONTH 12 DAY 6 YEAR 1987 | | 7b. HOUR 11:00 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 3 DAY 24 YEAR 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK AND BRANCH OF WORKING INDUSTRY) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Food Fair | |
| 13a. STATE Md | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Baltim | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Malcolm MIDDLE Doherty LAST Doherty | | 15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Morrison LAST Morrison | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217262520 | |
| 17. INFORMANT ADDRESS Gloria Doherty Same as #13e | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gram Negative Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) Spontaneous Bacterial Peritonitis
DUE TO, OR AS A CONSEQUENCE OF (c) Hepatom, Liver Cirrhosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hepatom, Liver Cirrhosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/01 , 19 87 , to 12/06 , 19 87 , that (I) (we) last saw the deceased alive on 12/06 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Sabah Al-Attar | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/06/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sabah AL-Attar | | 22e. ADDRESS St. Agnes Hospital, Balt. M.D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 12-7-87 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md. | |
| 24. FUNERAL DIRECTOR NAME Cremation Society of Md Inc. Balto. Md | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR DEC - 8 1987 | | 25b. REGISTRAR'S SIGNATURE Robert R. Anderson | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1001

1. The first part of the report is a general description of the project. It includes the title, the objectives, and the scope of the work. The title is "A Study of the Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope of the work is to study the reaction at temperatures between 20°C and 40°C.

2. The second part of the report is a description of the experimental procedure. It includes the materials used, the apparatus, and the method of carrying out the experiment. The materials used are hydrogen peroxide, potassium iodate, and sulfuric acid. The apparatus consists of a conical flask, a delivery tube, and a gas syringe. The method of carrying out the experiment is to mix a known volume of hydrogen peroxide with a known volume of potassium iodate in a conical flask. The flask is then placed in a water bath of known temperature. The reaction is allowed to proceed for a fixed time, and the volume of gas evolved is measured.

3. The third part of the report is a description of the results of the experiment. It includes a table of the data obtained, a graph of the rate of reaction against temperature, and a calculation of the activation energy. The data obtained is as follows:

| Temperature (°C) | Volume of gas evolved (cm ³) |
|------------------|--|
| 20 | 10.0 |
| 25 | 15.0 |
| 30 | 20.0 |
| 35 | 25.0 |
| 40 | 30.0 |

The graph of the rate of reaction against temperature is as follows:

The curve shows that the rate of reaction increases with temperature. The activation energy of the reaction is calculated to be 50 kJ/mol.

4. The fourth part of the report is a discussion of the results. It includes a comparison of the results with those of other workers, a discussion of the factors affecting the rate of reaction, and a conclusion. The results of this experiment are in good agreement with those of other workers. The factors affecting the rate of reaction are temperature, concentration, and surface area. The conclusion is that the rate of reaction increases with temperature.

5. The fifth part of the report is a list of references. It includes the names of the authors of the books and articles consulted, and the titles of the books and articles. The references are as follows:

- 1. "Chemistry for the 11th Standard", by P. W. Atkins, 1970.
- 2. "The Rate of Reaction", by J. H. Golding, 1965.
- 3. "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate", by J. H. Golding, 1965.

THE EFFECT OF TEMPERATURE ON THE RATE OF REACTION OF HYDROGEN PEROXIDE WITH POTASSIUM IODATE

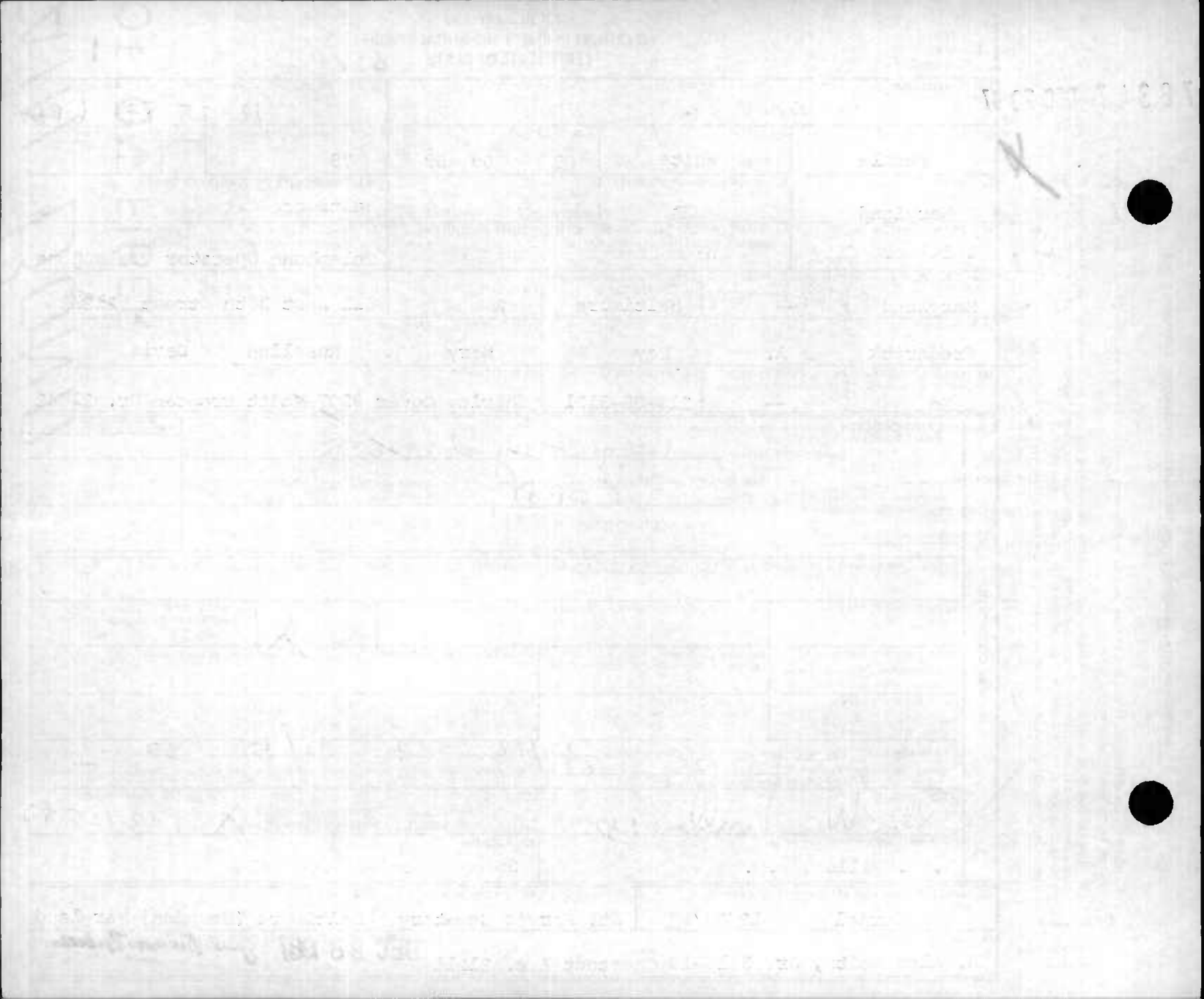
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | 8 7 | | 3 4 5 9 1 | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Evelyn R. Dolan | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 25 87 | | 2b. HOUR
6 PM | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
09 09 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Telephone Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Telephone | |
| 13a. STATE
Maryland | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
811 West 38th Street 21211 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frederick A. May | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Rosellen Davis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
-- | | 17. INFORMANT ADDRESS
218-05-3131 Shirley Cover 9307 Mediterranean Dr. 21842 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory distress</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u></u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> 19 <u>87</u> to <u>12/25</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (and I did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>P. W. Miller, M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. W. Miller, M.D. | | | | 22e. ADDRESS
Union Memorial Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore (Hampden) Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
A. Alan Seitz, Jr. | | | | ADDRESS
3615-19 Chestnut Ave. 21211 | | 25a. DATE REC'D BY REGISTRAR
DEC 28 1987 | | | |

BP



076821 DEC 31

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 4592

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ANNA R. DOPKOWSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
NOVEMBER 17, 1987 | | 2b. HOUR
12:17 PM | | | | |
| 3. SEX
F | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-2-1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS.
IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
3a. STATE
MD. | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS
2908 DILLON ST. 21224 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANTON GUNTNER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY HELGELT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-12-5579 | | 17. INFORMANT
ADDRESS
JOSEPH B. DOPKOWSKI SAME AS 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) PROBABLE UPPER GASTROINTESTINAL HEMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
APPROXIMATELY 24 HOURS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
THOMAS J. SKARDA | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
11/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS J. SKARDA | | | | 22e. ADDRESS
JOHNS HOPKINS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
11-20-87 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. HEART OF JESUS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. CO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
THOMAS J. SKARDA | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 24 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rudolf | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON MED DR. C. KOKES PER MR. V. CURVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

1. The first part of the report is a general description of the project. It includes the title, the objectives, and the scope of the work. The title is "A Study of the Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope of the work is to study the reaction at temperatures between 20°C and 40°C.

2. The second part of the report is a description of the experimental procedure. It includes the materials used, the apparatus, and the method of carrying out the experiment. The materials used are hydrogen peroxide, potassium iodate, and sulfuric acid. The apparatus consists of a reaction flask, a thermometer, and a stopper. The method of carrying out the experiment is to mix a known volume of hydrogen peroxide with a known volume of potassium iodate in the reaction flask, and then add a known volume of sulfuric acid. The time taken for the reaction to occur is measured by the time taken for the solution to turn blue.

3. The third part of the report is a description of the results of the experiment. It includes a table of the data obtained, a graph of the rate of reaction against temperature, and a calculation of the activation energy. The data obtained is as follows:

| Temperature (°C) | Time taken for reaction to occur (s) |
|------------------|--------------------------------------|
| 20 | 120 |
| 25 | 80 |
| 30 | 50 |
| 35 | 30 |
| 40 | 20 |

The graph of the rate of reaction against temperature is a straight line with a positive slope. The activation energy of the reaction is calculated to be 50 kJ/mol.

4. The fourth part of the report is a conclusion. It states that the rate of reaction increases with temperature, and that the activation energy of the reaction is 50 kJ/mol.

076519 DEC 30 87

541

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4593

| | | | | | | | |
|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Robert L. Dorsey SR | | | | 12/20/87 | | 7:55 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| m | Black | 2 16 32 | | 55 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| md | USA | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | John Peaton | | | Mixer (McComrick Co.) | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | | | |
| md. | | BALTO. | | 1419 Kingsway Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| RUFUS W. DORSEY | | ELSIE CONWAY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| YES | | 51-53 | | MRS. HAZEL DORSEY S/A | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) gm negative pneumonia | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) debilitation, 2 tracheostomy | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) subarachnoid hemorrhage. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| cerebral contusion, hydrocephalus, s/p pneumothorax | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/30 19 87, to 12/20 19 87, that (1) (we) last saw the deceased on 12/20 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| S. H. HARRIS MD. | | | | | | 12/21/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 12/28/87 | | DULANEY VALLEY | | TIMONIUM BALTO. MD. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| CHATMAN HARRIS FH | | | | DEC 29 1987 | | John A. Harris | |
| | | | | ADDRESS | | | |
| | | | | 1701 McGulloch St | | | |

MEDICAL CERTIFICATION

070011 112050

225 190 120 100 80 60 40 20 0

100 200 300 400 500 600 700 800 900 1000

1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

10000 20000 30000 40000 50000 60000 70000 80000 90000 100000

100000 200000 300000 400000 500000 600000 700000 800000 900000 1000000

1000000 2000000 3000000 4000000 5000000 6000000 7000000 8000000 9000000 10000000

10000000 20000000 30000000 40000000 50000000 60000000 70000000 80000000 90000000 100000000

100000000 200000000 300000000 400000000 500000000 600000000 700000000 800000000 900000000 1000000000

1000000000 2000000000 3000000000 4000000000 5000000000 6000000000 7000000000 8000000000 9000000000 10000000000

10000000000 20000000000 30000000000 40000000000 50000000000 60000000000 70000000000 80000000000 90000000000 100000000000

076590 DEC 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 34594

| | | | | | | | | | | | |
|---|--|---|---|--|----------------------------------|---|--|--|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Ruth ELIZABETH Dorsey | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 28 / 87 | | 2b. HOUR
4 ²⁵ A.M. | | | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 20 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balt City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NURSES AIDE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOSP. BON SECOURS | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2223 W. SARATOGA STREET BALTO, MD, 21223 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES SHAW | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
INEZ HARRINGTON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO. | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
099-14-5354 | | 17. INFORMANT MR. ADDRESS
MARSHALL T. DORSEY 2223 W. SARATOGA ST. BALTO, MD, 21223 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE cerebral infarction (left)
DUE TO, OR AS A CONSEQUENCE OF
(b) Left foot gangrene (toes)
DUE TO, OR AS A CONSEQUENCE OF
(c) Severe arteriosclerosis
Approximate interval between onset and death | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:10 | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26/87 to 12/28/87, that (I) (we) lost saw the deceased alive on 12/28/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/28/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Bernard Comella & M | | | | 22e. ADDRESS
200 W. Baltimore St., Md. 21223 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/31/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | | | | |
| 24. FUNERAL DIRECTOR
NUTTER FUNERAL HOMES, INC.
2501 GWYNNS FALLS PIKE, BALTO, MD, 21216 | | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

075918 DEC 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

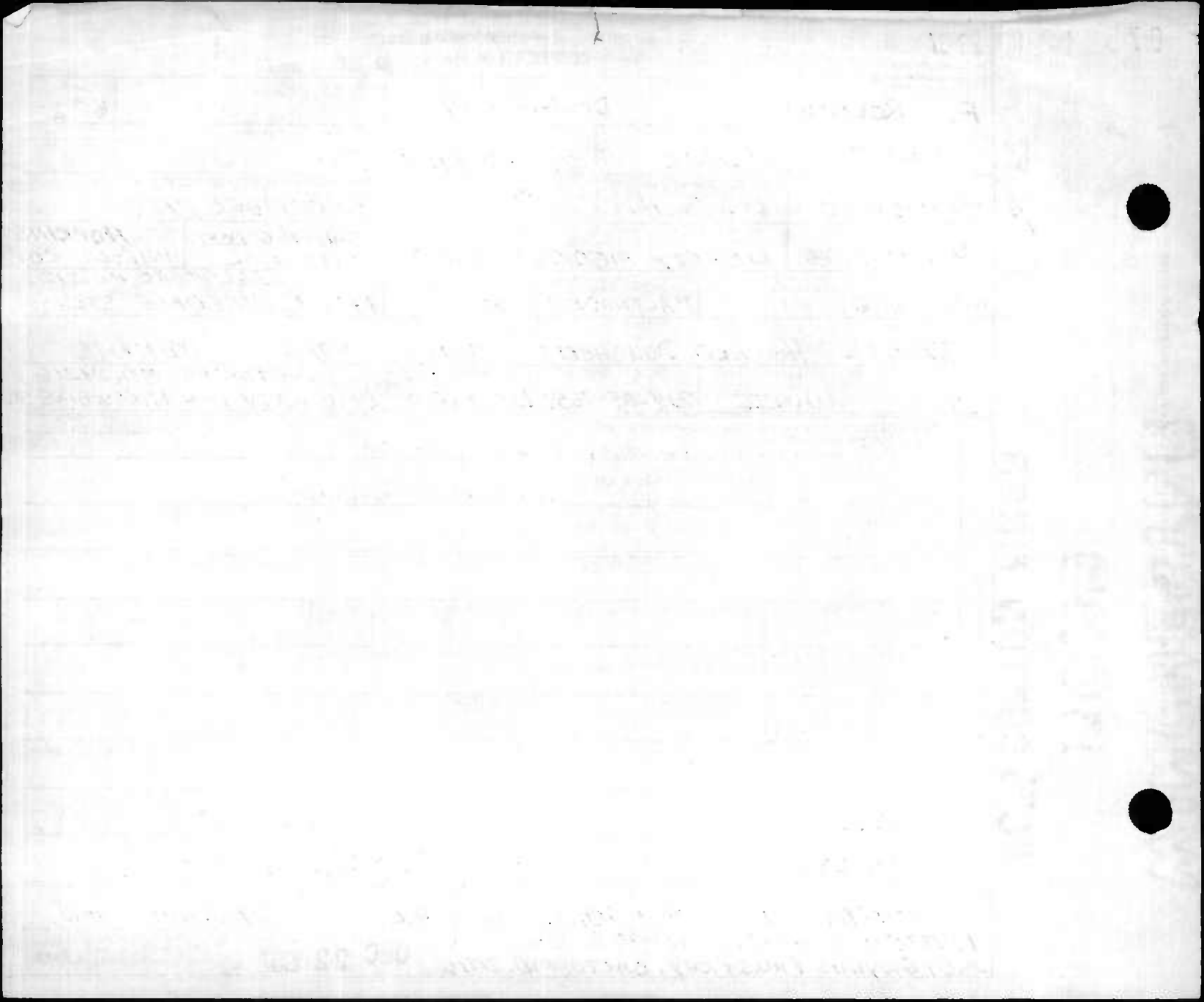
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
F. ROLAND DOUGHERTY | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-19-87 | | 2b. HOUR
5:32 A.M. | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 27 1917 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
70 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LIBERTY MEDICAL CENTER | | | | 12a. USUAL OCCUPATION
(TYPE WORK FOR US, NOT WORKING, RETIRED)
SHIPPING DEPT SUPERVISOR | | 12b. KIND OF BUSINESS OR INDUSTRY
HOPKINS UNIFORM CO. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
BALTIMORE, MD. 21216
1414 N. ROSEDALE STREET | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES HOWARD DOUGHERTY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY ETTA MINNIS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWT 218-05-9658 | | 17. INFORMANT
MRS. BALTIMORE, MD. 21216
LUVINIA M. DOUGHERTY 1414 N. ROSEDALE ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute myocardial infarction.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-18</u> , 19 <u>87</u> , to <u>12-19</u> , 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12-19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Matthew</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12-19-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Matthew | | | | 22e. ADDRESS
Liberty Medical Center
2600 Liberty Heights Ave. Baltimore. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/22/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
NORTH FUNERAL HOMES, INC.
2501 GWYNNS FALLS PKWY, BALTO, MD, 21246 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Jackson-Randall | | | |



076989 JAN 1989

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34596
REG. NO.

| | | | | | |
|---|-------------------------------------|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ARTHUR DOUGLAS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 27 / 87 | | 2b. HOUR
12:30 AM |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
6 28 23 | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
STATE OR FOREIGN COUNTRY
Mississippi | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Roofers | |
| 12b. KIND OF BUSINESS OR INDUSTRY
21201 | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE MD. 13c. COUNTY BALT. 13d. CITY OR TOWN BALT. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Beatrice Harris | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
1943-1945 428-36-4144 | | 17. INFORMANT
Mabel Moore 635 Silver St. Greenville, Mississippi | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Coronary Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CHRONIC RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCVD, Arrhythmia | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1, 1987, to 12/27, 1987, that (I) (we) last saw the deceased alive on 12/27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael Korallus | | | | 22c. DATE SIGNED
12/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL KAZAK | | | | 22e. ADDRESS
6810 BONNIE RIDGE, BALT. MD 21230 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-2-88 | | 23c. NAME OF CEMETERY OR CREMATORY
Delta Mem. Garden | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Greenville, Mississippi | | 24. FUNERAL DIRECTOR
NAME
Wm. L. BROWN 1206 W. North Ave | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | |

BP

100% COTTON

MADE IN U.S.A.

WASH & DRY

100% COTTON

DEC 28 1961

77055 JAN -5 87

FOR
STATE
REGISTRAR

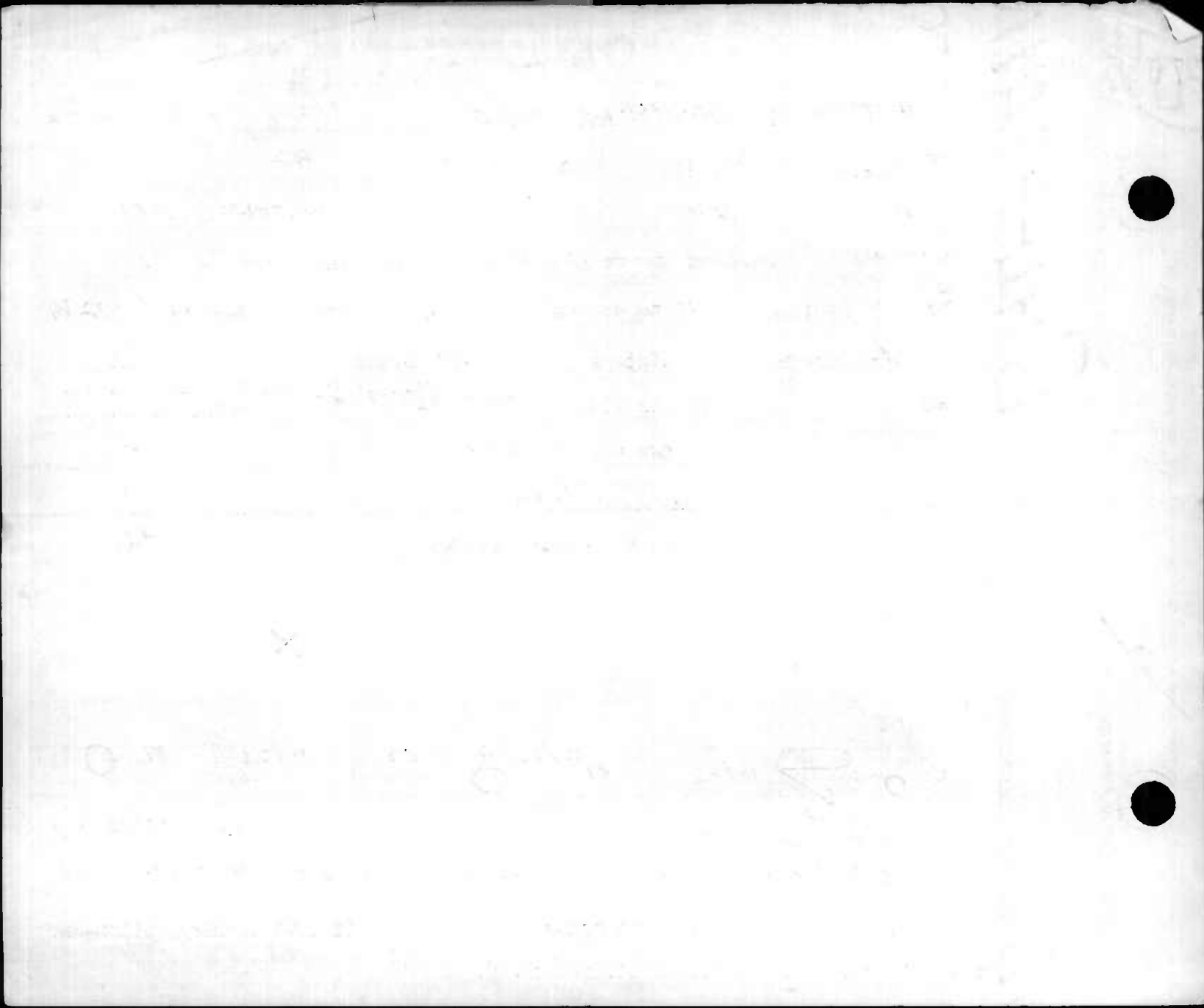
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 3 4 5 9 '7
REG. NO.

| | | | | | |
|--|--|---|--|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) MATTIE MATTIE LAKE DOUGLAS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 87 | | 2b. HOUR
00:22 AM |
| 3. SEX
F Female | 4. RACE
W White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 4 95 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UK | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MEDICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE PA | | 13b. COUNTY
Fulton | 13c. CITY OR TOWN
MERCERSBURG | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST UK George MIDDLE Winters LAST Lake | | 15. MOTHER'S MAIDEN NAME
FIRST UK Martha MIDDLE Lake LAST Lake | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
214 48 4068 | | 17. INFORMANT
Mrs. Lucille Weller ADDRESS 249 MD. Ave. Hancock, Md. 21750 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
899 IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF:
(b) HYPERTENSION
DUE TO, OR AS A CONSEQUENCE OF:
(c) 62% TBSSA BURNS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
0 min | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12 26 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22/87 , 19 87 , to 12/26 , 19 87 , that (I) (we) last saw the deceased alive on 12/26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
A.J. VAYLER, MD | | | | 22c. DATE SIGNED
12/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.J. VAYLER, MD | | | | 22e. ADDRESS
22 S. GREENVIEW ST. BALT. MD 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Damascus | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Big Cove Tannery, Fulton, Pa. | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1988 | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Grove Funeral Home 141 W. Main St. Hancock, Md. | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



078018 JAN 13 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO. 34598

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN D DOUKAS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 31 87 | | 2b. HOUR
3:40 PM |
| 3. SEX
FEMALE | 4. RACE
GREEK - W.H. | 5. DATE OF BIRTH
MONTH DAY YEAR
11 25 1918 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
69 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Westminster | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Joseph Richey House INC. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Fed. Govt. | | 12b. KIND OF BUSINESS OR INDUSTRY
Secretary |
| 13a. STATE
Md. | | | 13b. COUNTY
Wester | 13c. CITY OR TOWN
Westminster | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Theodore Doukas | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pauline Konstant | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
220-18-7694 | | 17. INFORMANT ADDRESS
James Doukas 703 Fairfield Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Lung & Brain metastases.
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of Breast
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
1 yr
7 yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) (this hospital) attended the deceased from 11-14 , 19 87 , to 12/31 , 19 87 , that (X) (we) lost
saw the deceased alive on 12-31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert C. Irwin M.D. | | | | DEGREE
M.D. | 22c. DATE SIGNED
1-1-88 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert C. Irwin M.D. | | 22e. ADDRESS
858 N. Euterost Baltimore Md 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(PRINT)
Burial | 23b. DATE
1-4-1988 | 23c. NAME OF CEMETERY OR CREMATORY
Eugene Memorial Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Finksburg Carroll Md | |
| 24. FUNERAL DIRECTOR
NAME
Thomas J. Fletcher | | ADDRESS
Westminster Maryland | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1988 | 25b. REGISTRAR'S SIGNATURE
 |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

76360 DEC 28

17. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 4599

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph - Dousa Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 26, 1987 | | 2b. HOUR
4:55 PM | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 28, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 74 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6410 Marietta Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS)
Supervisor - Gas Appliances | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6410 Marietta Avenue 21214 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph - Dousa Sr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eleanor Janda | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-05-4330 | | | 17. INFORMANT
ADDRESS
Mrs. Julia M. Dousa Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) Adenocarcinoma of the rectum 5 yrs. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/82 to 12/26/87, that (I) (we) saw the deceased alive on 11/26/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Louis E. Grenzer | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Louis E. Grenzer MD | | | | | | 22e. ADDRESS
1101 N. Calvert St. Baltimore, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 29, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1987 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-333-0-100

50



100-333-0-100

074216 DEC-7 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34600

| | | | | | | |
|--|--|---|--|--|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Leo DOZIER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 1, 1987 | | 2b. HOUR
7:00A M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/23/35 | | |
| 6. AGE (IN YEARS (LAST BIRTHDAY))
52 | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
Usa | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
307 Seagull Ave. 21225 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Isaiah Dozier | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pauline Dozier | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
248-56-8577 | | 17. INFORMANT
ADDRESS
David Dozier 3034 Southland Ave. 21225 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral mass of the lungs with aspiration
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 28, 1987 , to December 1, 1987 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 1, 1987 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (do) not view the body after death. | | | | | | |
| 22b. SIGNATURE
Marcel Zughayb, M.D. | | DEGREE
Attending Physician | | 22c. DATE SIGNED
12/1/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
c/o Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Park | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Estep Bros. F.H. 1300 Eutaw Pl. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC - 4 1987 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 22 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34601
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|
| DECEASED NAME
(TYPE OR PRINT) ANDREW S. DRAPER, Jr | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 21 87 | | | 2b. HOUR
1:18 M | | | |
| 3. SEX
male | | 4. RACE
B. 2 | | 5. DATE OF BIRTH
MONTH DAY YEAR
05 31 14 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DEATON HOSPITAL & Medical Center Retired | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
301 Mc Mechen St 21217 Apt 503 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Andrew | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Bell Saunders | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
216-01-0240 | | 17. INFORMANT
ADDRESS
Edgar D. Draper 2728 Longwood St | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary arrest | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Dissminated cancer of the prostate | | 7 years. | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | |

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
atherosclerotic cardiovascular disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1986 , to Dec 21 1987 , that (I) (we) lost
saw the deceased alive on Dec 21 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mohamed / Al-Israhim | | | | DEGREE
MD | | 22c. DATE SIGNED
12-21-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mohamed S. AL-ISRAHIM | | | | 22e. ADDRESS
22 S. Greene St Baltimore MD 21201 | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | | 23d. LOCATION
CITY OR TOWN COUNTY
Owings Mills MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. c. March F/H West 4300 Wabash Avenue | | | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | 26. REGISTRAR'S SIGNATURE
[Signature] | |

070588 DEC 30 11

100% COTTON FIBER

PAVEL M. BOWEN

DEC 30 1961

075167 DEC 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FGMV FORM 3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

34602

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. DATE KNOWN OF DEATH | | 2c. DATE PRONOUNCED DEAD | | 2d. DATE KNOWN OF DEATH | | 2e. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (IF NOT PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. DATE KNOWN OF DEATH | |
| Richard A. Dreves | | Male | | CAU | | 12 30 52 | | 34 | | 12/ 4/ 1987 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | |
| MD. | | USA | | NEVER MARRIED | | Baltimore City, MD | | Baltimore | | Southeast District Jail | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| PAINTER | | PAINT | | 16 N. Decker Ave | | Balto | | YES | | 16 N. Decker Ave | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17. ADDRESS | |
| George Dreves | | IDA Prince | | No | | 219-58-7412 | | Vivian Dreves | | 16 N. Decker Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hanging | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 6:25 P.M. 12/ 4/ 1987 | | subject hanged self in jail cell | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. INJURY OCCURRED | | 21h. PLACE OF INJURY | | 21i. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | cell | | Southeast District Jail, Balto. City, Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | | | | | | | | |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Dennis F. Smyth, M.D. | | Assistant | | 12/5/87 | | Burial | | 12/5/87 | | OAKLAWN | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 23d. LOCATION | | 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | |
| | | 111 Penn St., Balto., Md. 21201 | | Balto MD. | | Frank J. Decker | | 322 S. High St | | DEC 09 1987 | |

07-84
25M

BP

DHMH - 17
(VR A15 ME (1))

17510 100

+

30% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
STELLA DRUTZ DRUTZ | | | 2a DATE OF DEATH MONTH DAY YEAR
12-9-87 | | 2b HOUR
6:50 PM | |
| 3 SEX
FEMALE | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 14 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BEAUTICIAN | | 12b KIND OF BUSINESS OR INDUSTRY
COSMETOLOGY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
3615 FORDS LA. APT. 612 #21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MELVIN MARKOWITZ | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RUTH LOIS UNKNOWN | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b SOCIAL SECURITY NO.
218-32-4528 | | 17 INFORMANT
MRS. RUTHIE HOLSTEIN
2404 WILLOW GLEN DR. BALTO., MD 21209 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>CHF and restrictive lung disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-1</u> , 19 <u>87</u> , to <u>12-9</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>E. J. Selb</u> | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/9/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
E. J. SELB | | | | 22e ADDRESS
Sinai Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 11, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24 FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS. INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | | | | | |

1992

074935 DEC 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2b. DATE OF DEATH MONTH DAY YEAR | | 2c. HOUR | |
| | | RACHEL A. DURHAM | | | | DECEMBER 09, 1987 | | 3:33 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| F | | W | | 8-31-1902 | | 85 | | YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| VIRGINIA | | U. S. A. | | | | BALTIMORE CITY - MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTO. | | CHURCH HOSPITAL | | SEAMSTRESS | | TAILORING | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| MD. | | | | BALTO. | | | | 401 N. PORT ST. 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| WILLIAM CAMPBELL | | HATTIE | | | | 404-28-3919 | | Mr. Arthur Durham - 401 N. Port St. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC. 9 87</u> to <u>Nov 24 87</u> , that (I) (we) last saw the deceased alive on <u>19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>[Signature]</u> | | M.D. | | | | 12/9/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ADDRESS | | 22g. ADDRESS | | | |
| | | CHURCH HOSPITAL CORPORATION | | 100 N. BROADWAY, BALTIMORE, MD. 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 12-14-87 | | OAK LAWN CEM. | | BALTO., MD. | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>[Signature]</u> | | 7527 Harford Rd. | | DEC 11 1987 | | <u>[Signature]</u> | | | |

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

074033 10117

A

88

8-31-1901

W

T

FALL-MORE CITY

X

U.S.A

VIETNAM

ADMINISTRATIVE

CHURCH HOSPITAL

BALTO.

HOL N FORT ST 2125A

X

BALTO

-

MR.

HATTIE

CAMBERG

WILLIAM

HOL 22-SPR IN GALLER BUILDING - HOL N FORT ST 2125A

-

NO

1901

2125A - NO

1-14-01 Old 1901

DEC 1 1901

12-5-01 to 12-5-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34605

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
MARGUERITE MANGELS DUTROW

DATE OF DEATH MONTH DAY YEAR
December 19 1987

2b HOUR 15
3 AM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

9 MONTH 29 DAY 1900 YEAR

6. AGE (IN YEARS LAST BIRTHDAY)

87

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Meridian Long Green

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Secretary

12b. KIND OF BUSINESS OR INDUSTRY

Telephone

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

9609 Westcott Way 21236

14. FATHER'S NAME

FIRST Henry

MIDDLE William

LAST Mangels

15. MOTHER'S MAIDEN NAME

FIRST Amelia

MIDDLE

LAST Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

212-03-6141

17. INFORMANT

ADDRESS

Mary D. Weil 9609 Westcott Way 21236

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio Respiratory Failure

APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH

48 hrs

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

C.I.A. Hemorrhaged ASCVD

10 Days

5+ yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 20 July 19 50, to 19 Dec 19 87, that (I) (we) lost saw the deceased alive on 17 Dec 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c. DATE SIGNED

12-19-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Charles F. O'Donnell

22e. ADDRESS

7501 York Road 21204

23a. BURIAL, CREMATION, REMOVAL

BURIAL

23b. DATE

12-21-87

23c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

23d. LOCATION

Baltimore City

COUNTY

STATE Maryland

24. FUNERAL DIRECTOR

NAME

Mitchell-Wiedefeld Home 6500 York Road 21212

ADDRESS

25. DATE REC'D. BY REGISTRAR

DEC 24 1987

26. REGISTRAR'S SIGNATURE

Y 224 S 1B 39 04

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

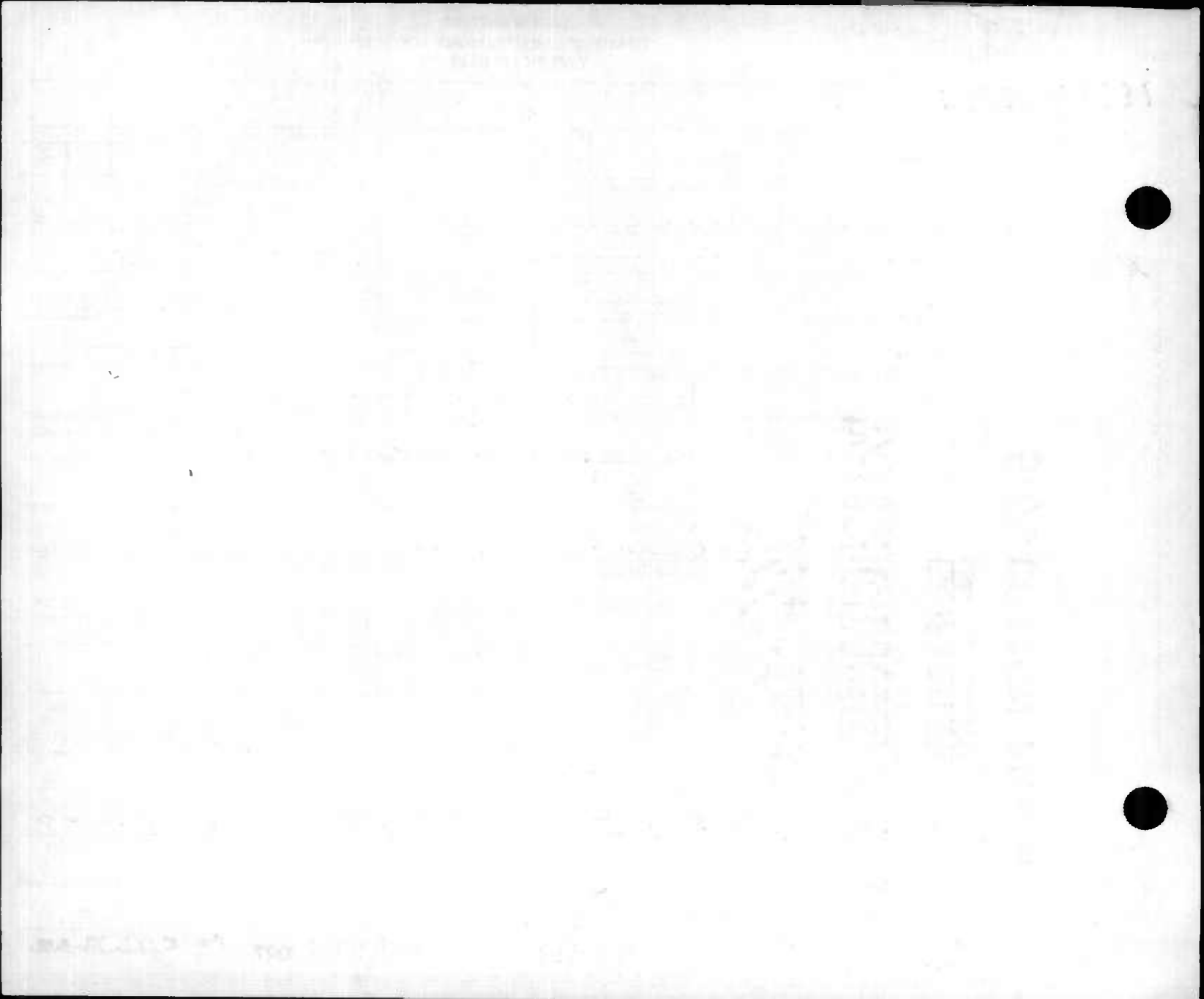
REG. NO.

8 7 3 4 5 0 6

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 20. DATE OF DEATH MONTH DAY YEAR | | 20. HOUR | |
| HELEN M. DUTTON | | | | DECEMBER 21 1987 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | WHITE | | APRIL 25 1900 | | 87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MD. | | U.S.A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | BEL AIR CONVALESCENTIUM | | UNEMPLOYED | | NONE | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD. | | | | | | BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| HARRY DUTTON | | | | CATHERINE LEIMKUHLER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | |
| NO | | 219-32-5978T | | IDA DEE (SISTER) SAME ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>extensive atherosclerotic cardiovascular disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>CHF</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>dissecting aortic aneurysm</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a- | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/17</i> , 19 <i>79</i> , to <i>12/21/87</i> , 19 <i>87</i> , that (I) was lost saw the deceased alive on <i>12/23</i> , 19 <i>87</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| <i>Joseph R. Liberto, MD</i> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | <i>12/24/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| DR. JOSEPH LIBERTO | | | | 3508 BANK ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 12/24/87 | | HOLY REDEEMER | | BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SCHIMMUNER FUNERAL HOME, INC. | | | | 3331 Brehms Lane Balto. Md. 21213 | | <i>DEC 23 1987</i> | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place this certificate in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.



077292 JAN - 88

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John, Arthur DuVall (Sr.) | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 31 87 | | | 2b. HOUR
8:45 PM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 14 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supt. Mat. | | 12b. KIND OF BUSINESS OR INDUSTRY
Calvert Dist. | | | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Ellicott City | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5203 Montgomery Rd. 21043 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Sylvester DuVall | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Olie Sills | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | | | 16b. SOCIAL SECURITY NO.
577-28-5819 | |
| 17. INFORMANT
Katherine C. DuVall, 5203 Montgomery Rd. 21043 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA LUNG.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) MALIGNANT PLEURAL EFFUSION
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27, 19 87, to 12/31, 19 87, that (I) (we) last saw the deceased alive on 12/31, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Latha R Pillai MD. | | | | | | | | 22c. DATE SIGNED
12/31/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Latha R Pillai | | | | | | 22e. ADDRESS
St Agnes Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Gary L. Kaufman, 5695 Main St., Elkridge, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1988 | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low register for the death certificate be executed within 24 hours of death. Page a may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

077029 JAN

FOR
STATE
REGISTRARLILLIAN L.
DYERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34608
REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Lillian Dyer</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12-28-87</i> | | 7b. HOUR
<i>4:50 PM</i> | |
| 3. SEX
<i>Fe</i> | 4. RACE
<i>Wht</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>3 19 07</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>80</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD | |
| 10. CITY OR TOWN OF DEATH
<i>Balt Md</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>MFL/FSK</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>SALES</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>DEPT. STORE</i> |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>BALTO</i> | 13c. CITY OR TOWN
<i>BALTO</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>RALPH --- rREESE</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>ELOISE --- CHEVEREL</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>no n/a</i> | | 16b. SOCIAL SECURITY NO.
<i>214302865</i> | | 17. INFORMANT
ADDRESS
<i>CLARENCE B. DYER 2023 LONGVIEW AVE 21237</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Encephalopathy</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Non Union Fr Left humerus</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Recurrent Aspiration - COPD - Recurrent CHF - Anemia</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-5-83</i> , 19 <i>83</i> , to <i>12-28</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>12-28</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>W.B. [Signature]</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12-28-87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>GRFZ NOW GH</i> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>12/31/87</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>GARDENS OF FAITH</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTO BALTO MD</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>[Signature]</i> | | ADDRESS
<i>[Signature]</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 30 1987</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver papers, Pages 1 and 2, to the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified of same.

BP

06-2-177-250-740

077391

JAN - 78

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 3 4 6 0 9
REG. NO.

| | | | | | | | |
|--|--|---|--|---|-----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SARAH DYER | | | 7a. DATE OF DEATH
MONTH DAY YEAR
12 27 87 | | 7b. HOUR
10:28 AM | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 26 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YEARS MONTHS DAYS
75 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
A.A.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
city MD | |
| 10. CITY OR TOWN OF DEATH
Balt City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hosp. | | 12a. USUAL OCCUPATION
(TYPE OR NAME FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
AA.C. | | 13c. CITY OR TOWN
Balt | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14a. FATHER'S NAME
FIRST MIDDLE LAST
Henry Brooks | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Watkins | | 16. STREET ADDRESS
6005 Ritchie Highway | | 16. ZIP CODE
21225 | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Y | | 18b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
Clark Dyer Jr. | | ADDRESS
6005 Ritchie Highway Baltimore, MD 21225 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a):

CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Hypertensive Arteriosclerosis**
DUE TO, OR AS A CONSEQUENCE OF **Cardiovascular disease**

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0:

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27 19 87 to 12/27 19 87 , that (I) (we) last saw the deceased alive on 12/27 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
SEENI VASANT | | | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
606 Hammond Lane, BALTO, 21225 | | | |

| | | | | | | | |
|--|--|-----------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
(CITY OR TOWN)
Baltimore, MD | |
| 24. FUNERAL DIRECTOR
NAME
Oden & Hixson | | | | ADDRESS
1634 Wood Hill | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1988 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove and keep properly. Page 4 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

1908

RECEIVED
JAN 10 1908
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

Jan 10 1908

1

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

Jan 10 1908

073093

NOV 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34610

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gussie E Eades | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Nov 19, 1987 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
2/27/1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(COUNTRY)
Ga. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3915 Callaway Ave. 21215 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Caterer | |
| 13a. STATE
MD | | | 13b. COUNTY | 13c. CITY OR TOWN
Balto | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Asthmatic bronchitis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Chronic Asthmatic bronchitis
DUE TO, OR AS A CONSEQUENCE OF
(c) 20 yrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
HCV & H/O CHF | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10/87 to 11/19/87 , that (I) (we) lost saw the deceased alive on 11/10/87 and that in my (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
E. J. Saunders | | DEGREE
MD | | 22c. DATE SIGNED
11/20/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. J. Saunders | | 22e. ADDRESS
Univ. of Md. Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
11/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Mem Cemetery Sluitland, Md | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR
NOV 24 1987 | | | |
| 24. FUNERAL DIRECTOR
NAME
Law Funeral H Ome | | ADDRESS
4611 Park Heights Ave. | | 25. REGISTRAR'S SIGNATURE
Julia Saunders | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
NOV 20 1967

10-11-67

10-11-67

NOV 20 1967

NOV 20 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| DECEASED NAME
(TYPE OR PRINT)
Lorraine Geraldine Eads | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 16, 1987 | | 2b. HOUR
1:15PM |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
8 03 1925 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
62 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Balto., Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2426 Liberty Heights Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife; cook | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Balto. City | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2426 Liberty Heights Ave. 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Boone | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Garrett | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]
No | | 16b. SOCIAL SECURITY NO.
220-18-6496 | | 17. INFORMANT
ADDRESS
Gregory Eads 536 S. Beechfield Ave 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma, right upper lobe</u>
DUE TO, OR AS A CONSEQUENCE OF
of lung -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a
<u>Carcinoma of ovary</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>May 23, 1987</u> to <u>December 16, 1987</u> , that (1) (we) last saw the deceased alive on <u>December 3, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Jeffrey M. Pargament</i> | | DEGREE
ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/17/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey M. Pargament, M.D. | | 22e. ADDRESS
9518-B Philadelphia Rd. Balt., Md. 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-22-87 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Brown/Thompson F.H. | | ADDRESS
P.O. Box 4433 (21223) | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1987 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

MEDICAL CERTIFICATION

075013 10 25 W

WILKINSON COLLEGE

WILKINSON

077499 JAN

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34612

| | | | | | |
|--|-------------------------|---|--|---|---------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Alice EASTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 24 87 | | 2b. HOUR
9 15 M |
| 3. SEX
FEMALE | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 08 97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Balti City | | | MD | | |
| 10. CITY OR TOWN OF DEATH
Balti | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SECON HILL NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSE WIFE | |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
CITY | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William TATE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BETSEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
CHART | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration Pneumonia | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 min. |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | |
| (b) _____
DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Severe ASCOD; Flexion Contractures

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-1 19 85 to 12-24 19 87 , that (I) (we) last saw the deceased alive on 12/24 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Jamie Punzalan | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12/26/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Punzalan | | 22e. ADDRESS
5714 Highland Rd. Balto. MD. 21214 | |

| | | | |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12/30/87 | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PK. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR
NAME
E. L. Phillips | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1988 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED
MAY 10 1915

DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

23155

23155

DATE 10-10-1911

43813 101100 2003

ONE

WINTER



10-10-11

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34614
REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
CHESTER | | MIDDLE
EDWARDS | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR | | 2b. HOUR | |
| | | | | | | | | 12 14 87 | | 4 47 P.M. | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 17 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MD | | 13c. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1027 N. Milton Ave. 21205 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
Army 117-01-8507 | | 17. INFORMANT
Ida Edwards | | ADDRESS
1027 Milton Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) CONGESTIVE HEART FAILURE.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) CARCINOMA OF COLON | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
SACRAL DECUBITUS ULCER, ARTERIO-SCLEROTIC HEART DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
- | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
- | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-25-1987 , to 12-14-1989 , that (I) (we) lost saw the deceased alive on 12-14-1989 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12-14-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUDHIR. D. PATEL | | 22e. ADDRESS
LIBERTY MEDICAL CENTRE
LIBERTY HEIGHTS, BALTIMORE MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST VET | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | ADDRESS | | 25. DATE REC'D. BY REGISTRAR
DEC 17 1987 | | 26. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, then the death certificate must be notified by police.

075116 DEC 1987

012511 12113

NOV 10 1964

012511

DEC 1 1964

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34615

| | | | | | | | | | | |
|---|--|---|--|--|-----------------|--|--|--|------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
STEVE | | MIDDLE
G. | LAST
EDWARDS | | 2a. DATE OF DEATH
MONTH
DECEMBER 2, 1987 | | YEAR
5; 15A M | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH
3
DAY
25
YEAR
17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7b. HOUR | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 10. HOUR | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECURITY | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | | 11. HOUR | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
327 EAST LANVALE STREET 21202 | | |
| 14. FATHER'S NAME
FIRST
HERSHEL | | MIDDLE | | LAST
EDWARDS | | 15. MOTHER'S MAIDEN NAME
FIRST
ANNIE | | LAST
EDWARDS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-07-9798 | | 17. INFORMANT
HELEN BATTLE 510 EAST 36th STREET | | ADDRESS | | 12. HOUR | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral edema/herniation</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Left MCA stroke</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebral embolism</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 h-s
4 d
4 d | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Chronic atrial fibrillation, old anterior MI, prosthetic aortic valve</u> | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20a. DATE OF OPERATION | | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20. HOUR | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21h. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21. HOUR | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 29</u> , 19 <u>87</u> , to <u>Dec. 2</u> , 19 <u>87</u> , that (I) (we) saw the deceased alive on <u>Dec. 2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b. SIGNATURE
<u>WORTHINGTON</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Dec. 2, 1987 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/7/87 | | 23c. NAME OF CEMETERY OR CREMATORY
MOUNT ZION CEMETERY | | 23d. LOCATION
CITY OR TOWN
LANSDOWNE, COUNTY STATE
MD | | 23. HOUR | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H, INC. | | ADDRESS
1101 E. NORTH AVENUE | | 25a. DATE REC'D BY REGISTRAR
DEC - 4 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Benson-Randall</u> | | 24. HOUR | | |

DIVISION OF VITAL RECORDS 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be completed within 24 hours after death. Page 4 may be
equipped by the hospital or attending physician.
3
010 7719
HIM
AND COMPLETED BY THE ATTENDING PHYSICIAN. If completed and filed in by the funeral director, page 3
TO FUNERAL DIRECTOR. After this certificate has been filed by the attending physician, it should be detached for use as the burial certificate with the appropriate page 4. Page 4 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene, prior to burial, cremation, or removal.
EDWARDS STEVEN
IMPORTANT: If item 21 is marked or item 18 (b) (3) (i) or (b) (7) traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15.4)

01-13-60

NOV 17 0 16
RECEIVED
U.S. AIR FORCE

DEC 4 1960

075218 DEC 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages 1 and 2 and return them to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as item 18, indicates any injury, or other traumatic event, a medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87-34616
REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE IN PRINT)
FIRST MIDDLE LAST
CHARLES A. EGERMAN | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 10 87 | | 2b. HOUR
8:55 AM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 19 15 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK, USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 XXXX YRS. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV OF MARYLAND HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CHEMICAL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
LAROCHÉ | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
NJ | | 13b. COUNTY
FAIRLAWN | | 13c. CITY OR TOWN
FAIRLAWN | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MORRIS XXXXXXXX EGERMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SABINA UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
XXXXXXXXXX NO | |
| 16b. SOCIAL SECURITY NO.
156-09-3066 | | 17. INFORMANT
SARA EGERMAN | | ADDRESS
(07410)
5-11 KARL STREET, FAIRLAWN, N.J. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ONE HOUR |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
ISCHEMIC CARDIOMYOPATHY | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/30, 1987, to 12-10, 1987, that (I) (we) last saw the deceased alive on 12-10, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
David A. Flick | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-10-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID A. FLICK | | 22e. ADDRESS
22 SOUTH GRAYNE STREET BALT MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
REMOVAL-BURIAL | | 23b. DATE
12/13/87 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR PARK CEM | |
| 23d. LOCATION
PARAMUS, | | COUNTY
N.J. | | STATE | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | |

BP

100-100000-100000

DEC 18 1961

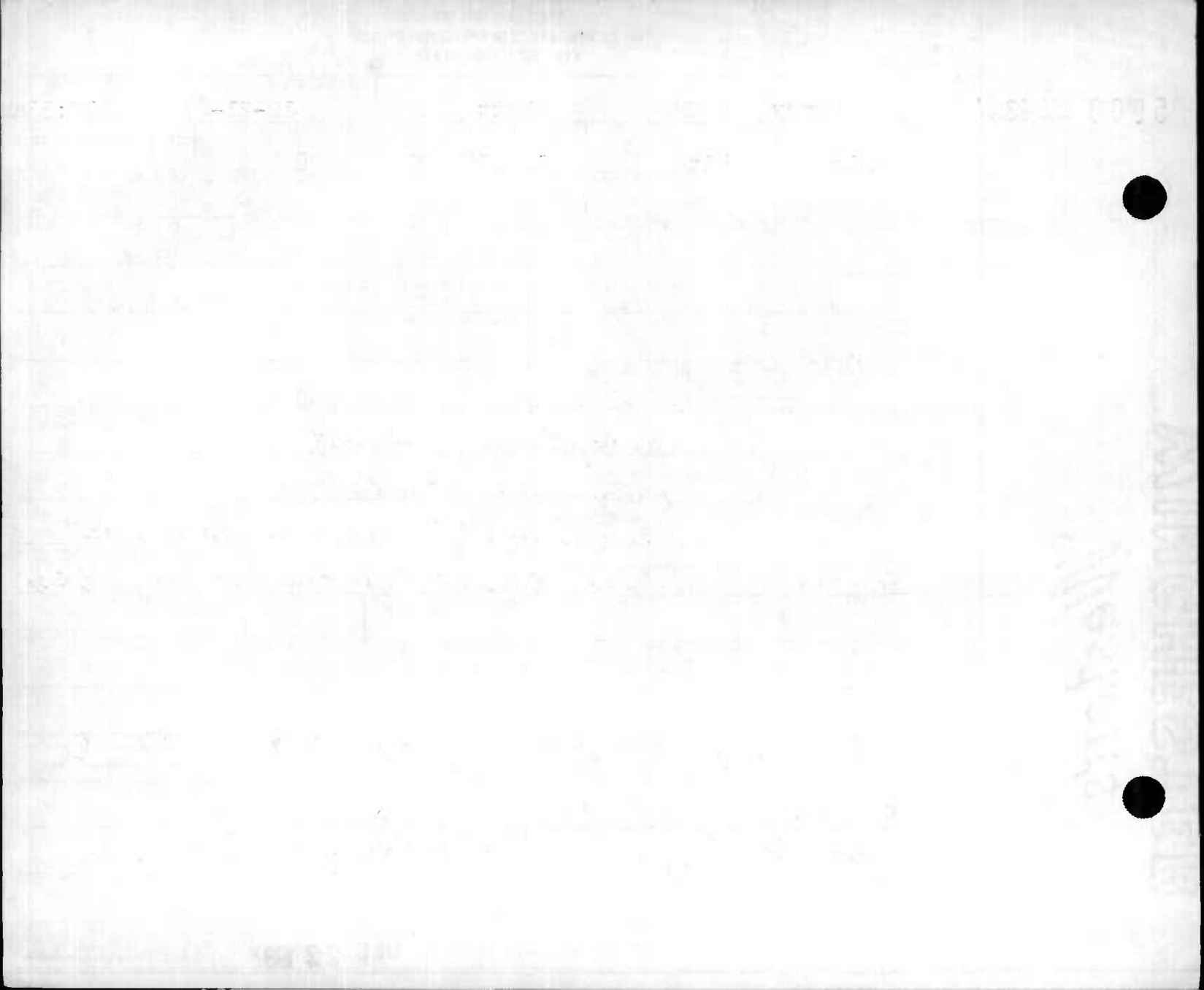
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|----------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Henry NMN Ehatt, Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-21-87 | | 7b. HOUR
10:33am | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 05 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
78 | | 7. UNDER 1 YEAR
MONTHS DAYS
0 0 | | 7. UNDER 24 HRS
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital CPER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Vice President | | 12b. KIND OF BUSINESS OR INDUSTRY
Business | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Arbutus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1242 Sulphur Spring Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George J. Ehatt | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Schneider | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-03-7662 | | 17. INFORMANT
ADDRESS
Helen N. Ehatt 1242 Sulphur Spring Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF
(c) previous multiple cardiovascular accident
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Seizure disorder, chronic obstructive lung disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
500 N. Rolling Rd. Catonsville | | | | | | | |
| 22a. I certify that (i) this hospital attended the deceased from 4-1 , 19 87 , to 12/21 , 19 87 , that (ii) we last saw the deceased alive on 11-21 , 19 87 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R. Sirgy | | | | DEGREE
Attending Physician | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Raeford L. Sirgy | | | | 22e. ADDRESS
500 N. Rolling Rd. Catonsville | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Ambrose Funeral Home 1328 Sulphur Spring Road | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Swenson-Randall | | | | | |

BP



077038 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
58 REGISTRAR

| | | | | | | | |
|---|---|---|--------------------------------|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
ALBERT | MIDDLE
J. | LAST
EHMS | 2a. DATE OF DEATH
MONTH DAY YEAR
12 - 30 - 1987 | | 2b. HOUR
M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
06 - 20 - 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
402 S. COLLINGTON AVE. 21231 | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNION REPRESENT | | 12b. KIND OF BUSINESS OR INDUSTRY
CONTINENTAL CAN | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
-- | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
402 S. COLLINGTON AVE. 21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM -- EHMS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA C. KNEUCKER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
ADDRESS
JOSEPH SPEAR 3321 SHANNON DR. 21213 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Heart ASCVD -</i>
DUE TO, OR AS A CONSEQUENCE OF <i>Diabetes, Atherosclerosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1918</i> to <i>1987</i> , that (I) (we) last saw the deceased alive on <i>9-7-87</i> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Theresa R. Smith</i> DEGREE | | | | 22c. DATE SIGNED
<i>12-30-87</i> | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>T. R. WIZNIK</i> | | | | 22f. ADDRESS
<i>4295 Chesler St</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
01/02/87 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
LILLY & ZEILER, INC. 1901 EASTERN AVE. 21231 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>John L. ...</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07703 100

9



RECEIVED
JAN 10 1903

RECEIVED
JAN 10 1903

RECEIVED
JAN 10 1903

077633 JAN 11 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LOUIS EICH | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-11-1987 | | | 2b. HOUR A M
5:45 A | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
1-7-05 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
82 | | IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belair Convalesarium | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
TORENZ EICH | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
EMILIE SCHWARTZ | | | 13e. STREET ADDRESS / ZIP CODE
10116 Belair Rd 21206 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
MA LOUIS EICH 2926 ERDMAN AVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory Failure
DUE TO, OR AS A CONSEQUENCE OF Coccygia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) Adenocarcinoma of Cecum
(c) ?
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
months | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Recent Pneumonia, recent Cardiovascular Accident | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8/87 to 12/11/87 , that (I) (we) last saw the deceased alive on 12/8/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Albert B. Bradley | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/11/87 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Albert B. Bradley | | | | | 22e. ADDRESS
4900 Belair Rd. BALTO. MD 21206 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
C | | | 23b. DATE
11/5/88 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenland Co | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME
Joseph L. Russ | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1988 | | 25b. REGISTRAR'S SIGNATURE
John F. ... | | | |

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 28th inst. in relation to the above matter.

I am sorry to hear that you are having trouble with your machine. I will try to get it fixed as soon as possible.

I am, Sir, very respectfully,
Yours truly,
J. L. Smith

RECEIVED
JAN 1 1930

077493 JAN -78

#18a, 2 Film G635 1/18/88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4620

| | | | | | | | | |
|--|-------------------------|--|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
LILLIAN EISENBERG | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH DAY YEAR
12-31-87 | | | 2b. HOUR
M | | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG. 25, 1903 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
84s. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
12-31-87 | 7d. HOUR
9am | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7211 Park Hgts, Avenue Apt. 206 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
OFFICE MANAGER | | 12b. KIND OF BUSINESS
SPECIALTY CANDY CO. |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTO | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET ADDRESS
7211 PARK HTS. AVE., APT. 206 (21208) | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HYMAN EISENBERG | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BESSIE ADLER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
212-01-5960 | | 17. INFORMANT ADDRESS
MRS. MARILYN SILVERSTEIN APT. 305 (21209) 6300 RED CEDAR PI | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
Alzheimer's disease and Parkinson's disease
IMMEDIATE CAUSE (a) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Alzheimer's disease and Parkinson's disease | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | TITLE (SPECIFY)
Assistant | | | DATE SIGNED
12-31-87 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/1/88 | | 23c. NAME OF CEMETERY OR CREMATORY
ANSHE NEISEN CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO MD | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1988 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 C. | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT RECV. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MA

BP

DHMH - 17
(VR A15 ME (5))

2022 COTTON LIBER

UNION
MAY 1911



3. 11. 11

074837 DEC 11 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

34621

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Fannie

Mae

Ellen

2a. DATE OF DEATH
KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR
12 2 19 87

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

2d. HOUR

FEMALE

BLACK

5 30 30

57 YRS.

MONTHS

DAYS

HOURS

MIN.

12 7 19 87

10:50

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MD

USA

Baltimore City

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

Baltimore

2543 E. Biddle Street

UNEMPLOYED

N/A

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

MD

BALTIMORE

YES ☒ NO ☐

2543 E. BIDDLE STREET 21213

FATHER'S NAME

FIRST

MIDDLE

LAST

LOWEN

THAL

JOHNSON

15. MOTHER'S MAIDEN NAME

MIDDLE

LAST

ELIZABETH

ELLISON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

NO

218-28-4538A

LUKE JOHNSON 5808 BLAND AVENUE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

PARTIAL

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

HOUR A.M. MONTH DAY YEAR
P.M. 19

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 12/7/87

EXAMINER'S NAME (TYPE OR PRINT)

Mario F. Golle, Jr, M.D.

ADDRESS 111 Penn St.

Balto., MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY

STATE

BURIAL

12/12/87

EASTVIEW MEMORIAL PARK

DUNDALK, MD

MD

24. FUNERAL DIRECTOR NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

WM. C. MARCH F/H 1101 E. NORTH AVENUE

DEC 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 10.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

100-100-100-100

WINDY WATERS

GREEN MOUNTAIN

100-100-100-100

076018 DEC 23 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Layford B Ellis | | | 2a. DATE OF DEATH
MONTH 12 DAY 18 YEAR 87 | | 2b. HOUR
5:48 M |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH 8 DAY 17 YEAR 46 | | 6. AGE (IN YEARS LAST BIRTHDAY)
41 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
SC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| 13a. STATE
MD | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1617 W. Lanvale Street 21217 | |
| 14. FATHER'S NAME
FIRST Layford MIDDLE Ellis Sr. LAST Ellis Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST Henrietta MIDDLE Pinckney LAST Pinckney | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Barbara A. Ellis 604 Cherrycrest Apts. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic encephalopathy
DUE TO, OR AS A CONSEQUENCE OF (b) alcoholic hepatitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Malnutrition, chronic alcoholism | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (his hospital) attended the deceased from 12/18/87 to 12/18/87 , that (I) (we) last saw the deceased alive on 12/18/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (a) (d) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Beltran | | DEGREE MD | | 22c. DATE SIGNED
12/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JUAN A. BELTRAN | | 22e. ADDRESS
1940 W. BALTIMORE ST, BALTO | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
12/23/87 | 23c. NAME OF CEMETERY OR CREMATORY
SELMA GRAVEYARD | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
VANCE SC 21223 |
| 24. FUNERAL DIRECTOR
NAME WM. C. MARCH F/H, INC. ADDRESS 1101 E. NORTH AVENUE | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1987 | | 25b. REGISTRAR'S SIGNATURE
Juan Beltran-Rodriguez |

BP

074332 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34623
REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Carter Eloise | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 06 87 | | 2b. HOUR
2:35 A.M. | |
| 3 SEX
Female | 4 RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
04 07 50 | | 6 AGE (IN YEARS LAST BIRTHDAY)
37 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty medical center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Balto. City | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Turner Pugh | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
193-26-2871 | | 17 INFORMANT
ADDRESS
William Pugh 2853 Ethelbert Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestive Heart failure.
DUE TO, OR AS A CONSEQUENCE OF
(c) Cardiac arrhythmia. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/04 19 87 to 12/06 19 87 , that (I) (we) lost
saw the deceased alive on 12/06 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
T. Ohiorokpenai, m.d. | | DEGREE
MD | | 22c. DATE SIGNED
12/06/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. Ohiorokpenai, m.d. | | 22e. ADDRESS
Liberty medical Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/10/87 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. |
| 24. FUNERAL DIRECTOR
NAME
C. Hainwright | | ADDRESS
2700 Edmondson | | 25. DATE REC'D. BY REGISTRAR
DEC 07 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Benson-Rodgers | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

PLANT INDUSTRY

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

6498 DEC 30 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Lillian</u> <u>EMMA</u> <u>E</u> <u>LILLIAN</u> <u>Emge</u> <u>EMGE</u> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>12-24-87</u> | | 2b. HOUR <u>2:50</u> <u>A</u> <u>M</u> | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>07-22-02</u> | | 6. AGE (IN YEARS (LAST BIRTHDAY)) <u>85</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore, Maryland</u> MD | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | |
| 13a. STATE <u>Maryland</u> | | | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>George</u> <u>Kelly</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lillian</u> <u>McNear</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | | | 16b. SOCIAL SECURITY NO. <u>216-20-4331</u> | | 17. INFORMANT ADDRESS <u>George E. Emge Balto., Md. 21234</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metabolic Encephalopathy</u> , <u>Metastatic CA Glon</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal insufficiency</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (if this hospital) attended the deceased from <u>11-01-1987</u> to <u>12-24-1987</u> , that (we) last saw the deceased alive on <u>12-24-1987</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>12/24/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>AMAEFALLE</u> | | | | 22e. ADDRESS <u>South Baltimore General Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>12/28/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>McCully Funeral Homes Balto., Md. 21225</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 29 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

BP

1200000 0000

Handwritten notes and calculations, including the number 78.

Vertical handwritten text on the left side, possibly a list or index.

074349 DEC -8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34625

| | | | | | |
|--|--|---|---|--|--|
| DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELIZABETH CECELIA ENGEL | | | 20. DATE OF DEATH
MONTH DAY YEAR
12 6 87 | | 21. HOUR
7:45A.M. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
6 9 26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
321 S. Gilmore Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
--- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT DITTY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JESSIE E. THOMPSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-18-4757 | | 17. INFORMANT
ADDRESS
21223
PAULETTE M. THOMPSON 321 S. GILMORE ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic colon adenocarcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE
<i>[Signature]</i> | | 22c. DATE SIGNED
12/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gormley | | 22e. ADDRESS
St. Agnes Hosp. Oncology Dept. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/9/87 | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | ADDRESS
21229
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC - 7 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

NO-33 246170

DO NOT WRITE HERE

RECEIVED

COPIES OF REPORT
TO ALLIED AIRWAYS

DEC 1944

075759 DEC 22 1987

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH3.4626
REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---------------------------------|--|--|--|---|--|---|--|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ernest | | FIRST | | MIDDLE | | LAST
English | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12/ 17/ 87 | | | | 2b. HOUR
5:50 P | | | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 2 34 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12/ 17/ 87 | | 7d. HOUR
5:50 P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1633 Ramblewood Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1633 RAMBLEWOOD ROAD | | | | 21239 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT ENGLISH | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA GRACE | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES
NO | | | | 16b. SOCIAL SECURITY NO.
251-54-4728A | | | | 17. INFORMANT ADDRESS
KILOUGH ENGLISH 1633 RAMBLEWOOD RD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Colon
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY)
MD Assistant | | | | MEDICAL EXAMINER | | DATE SIGNED 12/18/87 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
12/22/87 | | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW MEM. PK. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DUNDAL MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1987 | | | | 25b. REGISTRAR'S SIGNATURE
<i>J. Gordon</i> | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM (M-1) CONTAINING PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

80 90 100 110 120 130 140 150 160 170 180 190 200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

67 34627

| | | | | | |
|--|---|---|---|---|--|
| DECEASED NAME
(TYPE OR PRINT)
THOMAS EDWARD ENGLISH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
WED., DECEMBER 3 1987 | | 2b. HOUR
7:45A M. |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 16, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
U S OF A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5439 GIST AVENUE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
SHIPYARD |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
5439 GIST AVENUE 21215 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN ENGLISH | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAGGIE DAVIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
238 28 9523A | | 17. INFORMANT
ADDRESS
MRS. MARIE ENGLISH 5439 GIST AVE. 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular disease</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Coronary heart failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) see the body after death. | | | | | |
| 22a. SIGNATURE
<i>Martin J. Sheridan</i> | | DEGREE | | 22c. DATE SIGNED
12/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/7/87 | 23c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FREDERICK CO., MD. |
| 24. FUNERAL DIRECTOR
NAME
LEWIS T. GWYNN | | ADDRESS
4517 PARK HEIGHTS AVE. 21215 | | 25a. DATE REC'D. BY REGISTRAR
DEC - 4 1987 | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> |

BP

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

x

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

073747 DEC -287

Items, 18, 18b, 21a-22a., G-634., by Med. Ex.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. 4. 6 2 8

| | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|---|--|------------------------------------|--|--|----------------|-------------------------------|--|---|--|-------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| William Lloyd Ennis | | | | | | 11-4 19 87 | | | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | |
| MALE | | WHITE | | 2 14 87 | | - YRS. | | 8 21 | | 11-4 19 87 | | 1:45 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | | | USA | | | | | | | | Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | Johns Hopkins Hospital | | | | N/A | | | | N/A | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| MARYLAND | | | | WICOMICO | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 843 BROWN STREET/21801 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| DONALD LEE ENNIS | | | | BILLIE SUE STURGIS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | |
| NO | | | | 218-13-1801 | | | | MARY L. DORSEY, SALISBURY, MD | | | | 21801 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Anoxic encephalopathy | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (b) positional asphyxia | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 2:00 PM 11 1 19 87 | | | | head caught between mattress and railing of crib | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| home | | | | 843 Brown Street | | | | Salisbury, | | - | | Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| Margarita A. Korell, M.D. | | | | Assistant | | | | 11-5-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn St., Balto., Md. | | | | 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| BURIAL | | | | 11-8-87 | | WICOMICO MEMORIAL PARK | | | | SALISBURY, WICOMICO, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| ZELLER FUNERAL HOME, SALISBURY, MD | | | | 21801 | | | | NOV 30 1987 | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

01317 EDO-501

2022 COLLECTION

UNIVERSITY OF MARYLAND



0

BY - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34629

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LEON | | FIRST
LEON | | MIDDLE
ENOCH | | LAST
ENOCH | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 20, 1987 | | 2b. HOUR
2:20 P.M. | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 12, 1912 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
75 YRS. | | 7a. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 7b. IF UNDER 24 HRS.
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
PRINTING | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2901 TERRY DRIVE, APT. E (21209) | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DAVID ENOCH | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FRIEDA EINHORN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
126-34-2506 | | 17. INFORMANT
ADDRESS
MALA ENOCH 2901 TERRY DR., APT. E (21209) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/21/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
angioplasty | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10 00 12/21/87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
fall | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
HOME | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
600 Light St BALTO. BALTO. MD | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 20, 1985 to December 20, 1987 , that (I) (we) last saw the deceased alive on December 1, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23a. SIGNATURE
Alan M. Adelman, MD | | | | | | | | DEGREE
MD | | 23c. DATE SIGNED
12/21/87 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
Alan Adelman, MD | | | | | | 23d. ADDRESS
600 Light St Baltimore, MD 21201 | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 24b. DATE
12/21/87 | | 24c. NAME OF CEMETERY OR CREMATORY
BETH TFILOH CEM | | 24d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. BALTO. MD | | 24e. DATE REC'D. BY REGISTRAR
DEC 23 1987 | | | |
| 24f. REGISTRAR'S SIGNATURE
SOL LEVINSON & BROS. INC. | | | | | | 24g. REGISTRAR'S SIGNATURE
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

Handwritten notes and signatures are visible across the page, including a large 'X' mark in the center and various illegible scribbles and lines.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 37 34630

1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|---|---------------------------------|--|
| 2. DECEASED NAME
(Last, first, middle, initial)
SUSANNE B EPPLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 16, 1987 | | 2b. HOUR
MIN.
3:30 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
September 4, 1924 | | |
| 6. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. CITY OR TOWN OF DEATH
BALTIMORE | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Homemaking | | |
| 13a. STATE
Pennsylvania | | 13b. COUNTY
York | | 13c. CITY OR TOWN
York | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gilbert G. Miller | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marian E. Socks | | 16. SOCIAL SECURITY NO.
196-187040 | | |
| 17. INFORMANT
ADDRESS
Philip W. Eppley, 133 Woodthrush Lane, | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC BREAST CANCER
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 4, 1987 to Dec 16, 1987 , that (I) (we) last saw the deceased alive on Dec 16, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Sydney Yoon | | DEGREE
MD | | 22c. DATE SIGNED
12/16/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SYDNEY YOON | | 22e. ADDRESS
600 N. Wolfe St. Balto. MD 21205
JOHNS HOPKINS HOSP | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Susquehanna Mem. Grdns. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
York, York County, PA | | 24. FUNERAL DIRECTOR
NAME
Martin D. Lawson | | 25a. DATE REC'D BY REGISTRAR
DEC 21 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | | 26. REGISTRAR'S NAME
Julia Anderson-Randall | | | | |

155-1-1025

8

155-1-1025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2, 3, and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34631

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|---|--|-----------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| BESSIE EPPS | | | | | | | | 12/19/87 | | | | | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | MONTH | | DAY | | YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | BLACK | | 10/23/1906 | | | | | | | | 81 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BLACKSTONE, VA | | USA | | | | BALTO. CITY | | BALTO. | | 1400 E. MADISON AVE. | | | | | | MD | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | 1400 E. MADISON AVE. | | | | | | | |
| MD | | | | BALTO. | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | | | |
| JUBBER EPPS | | | | | | MARATHA EPPS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | N/A | | 229 22 9792 | | JAMES EPPS 2008 RIDGEHILL AVE. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Respiratory Arrest | | | | | | | | | | | | 8 minutes | |
| | | | | | | Asthma | | | | | | | | | | 5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from July 19, 87, to November 19, 87, that (we) last saw the deceased alive on October 19, 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | | | | |
| Earl Hope | | MD | | | | 12/22/87 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| Earl Hope, MD | | Johns Hopkins Hospital, Balto MD 21205 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| BURIAL | | 12/24/87 | | EASTVIEW CEM. | | BALTO., MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| LEROEY O. DYETT | | 4600 LIBERTY HEIGHTS AV. | | | | DEC 22 1987 | | Julia Foster-Randall | | | | | | | | | |

BP

10-25-77 10:00 AM

10-25-77 10:00 AM

10-25-77 10:00 AM

10-25-77 10:00 AM

074789 DEC 14

07- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

4 6 3 2

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>King D. Epps JR.</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 09 87</i> | | 2b. HOUR
<i>4:20 P</i> |
| 3. SEX
<i>M</i> | 4. RACE
<i>B V</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>02 01 53</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>34</i> YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>CITY</i> MD | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Univ of Md</i> | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
<i>Disabled</i> | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>MD</i> | | | 13b. COUNTY | 13c. CITY OR TOWN
<i>Baltimore</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>King D. Epps</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Magnolia Brogdon</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>212 56 8492</i> | | 17. INFORMANT
<i>Magnolia Epps</i> | |
| | | | | ADDRESS
<i>1711 W. Baltimore St</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>RESPIRATORY ARREST</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
<i>End Stage Renal Disease</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/19 87</i> to <i>12/14 87</i> , that (I) (we) saw the deceased alive on <i>12/19 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>R. Hustig MD</i> | | DEGREE | | 22c. DATE SIGNED
<i>12/19/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>R. Hustig</i> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/14/87</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Garrison Forest Vet</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Owings Mills MD</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Wm. C. March F/H West 4300 Wabash Avenue</i> | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 11 1987</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Swenson-Randall</i> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, New York, NY; 789 Oak Street, New York, NY; 101 Pine Street, New York, NY; and 202 Cedar Street, New York, NY.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, New York, NY; 789 Oak Street, New York, NY; 101 Pine Street, New York, NY; and 202 Cedar Street, New York, NY.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, New York, NY; 789 Oak Street, New York, NY; 101 Pine Street, New York, NY; and 202 Cedar Street, New York, NY.

4. The fourth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, New York, NY; 789 Oak Street, New York, NY; 101 Pine Street, New York, NY; and 202 Cedar Street, New York, NY.

5. The fifth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Smith, James Brown, William Jones, Robert Taylor, and Thomas White. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, New York, NY; 789 Oak Street, New York, NY; 101 Pine Street, New York, NY; and 202 Cedar Street, New York, NY.

077434 JAN 7 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

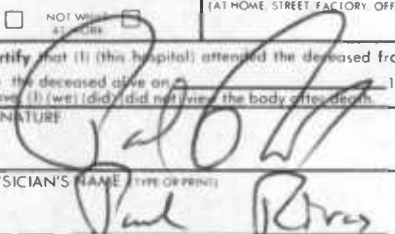
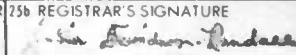
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|---|--|--|--|--|---|--|--|
| FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
LOUISE | | FIRST | MIDDLE | LAST
ESSIG | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 87 | 2b. HOUR
8:45 A M |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
3 5 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
99 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore Md | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD | | | |
| 10. CITY OR TOWN OF DEATH
Cockeysville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND MASONIC HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
California | | 13b. COUNTY
San Luis | 13c. CITY OR TOWN
San Luis | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3000 Augusta St. 93401 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Schmoll | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Spittel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-09-1370 | | 17. INFORMANT ADDRESS
Maryland Masonic Homes, Cockeysville, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pulmonary CA
DUE TO, OR AS A CONSEQUENCE OF
(c) Colon CA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
 | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-30-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul B. Brown | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Jan. 2, 1988 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | 25a. DATE REC'D BY REGISTRAR
JAN 6 1988 | | 25b. REGISTRAR'S SIGNATURE
 | | |

15510

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

15510

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST
HANS

MIDDLE
Peter

LAST
EUGSTER

2a DATE OF DEATH MONTH DAY YEAR
DECEMBER 17, 1987

2b HOUR
5:22 M

1 SEX

Male

4 RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
November 19 1925

6. AGE (IN YEARS LAST BIRTHDAY)

62

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Switzerland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10 CITY OR TOWN OF DEATH

BALTIMORE

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

THE JOHNS HOPKINS HOSPITAL

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Professor

12b KIND OF BUSINESS OR INDUSTRY

College Geology

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Baltimore

13c CITY OR TOWN

Freeland

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

2613 Beckleysville Rd 21053

14 FATHER'S NAME

FIRST
Conrad

MIDDLE

LAST
Eugster

15 MOTHER'S MAIDEN NAME

FIRST
Marie

MIDDLE

LAST
Busch

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
No

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)
577-48-8148

17. INFORMANT

Elaine H. Eugster

ADDRESS

Same as 13e

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

electromechanical dissociation

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

40 min

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) probable aortic dissection

1 day

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/17 19 87, to 12/17 19 87, that (I) (we) lost

saw the deceased alive on 12/17 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

AMY KLION

22e. ADDRESS

JOHNS HOPKINS HOSPITAL, MD. 21205

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b. DATE

12/19/87

23c. NAME OF CEMETERY OR CREMATORY

Westview Memorial Park

23d. LOCATION

Catonsville

CITY

Baltimore

STATE

MD

24 FUNERAL DIRECTOR

George J. Gonce 4001 Ritchie Hwy Balto Md

25a. DATE REC'D BY REGISTRAR

DEC 21 1987

25b. REGISTRAR'S SIGNATURE

RELEASED AS NON MED - DR. SMYTH PER MR. B. HENRY 12/17/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certificate pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1575 100000

DEL 11 1901

027769 JAN 12 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 4 6 3 5
REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CATHERINE M. EVANS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 28 87 | | 2b. HOUR
M
 |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
6 02 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
71 | IF UNDER 1 YEAR
MONTHS DAYS
 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4916 GREENSPRING AVE. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DEPT. OF ED. | |

| | | | | | | |
|---|--|--|--|---|---|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4916 GREENSPRING AVE. 21209 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MELVIN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET JOHNSON | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO. | | 16b. SOCIAL SECURITY NO.
578-16-0724 | | 17. INFORMANT
ADDRESS
BALTIMORE, MD, 21229
BERNICE A. COOK 416 EDGEWOOD STREET | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of the Lung. | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 yr. |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

Bladder cancer (1984); Chronic Obstructive Pulmonary Disease.

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from July 1 19 85 to December 28 19 87 , that (b) (we) last saw the deceased alive on December 17 87 , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above. (c) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE
George Taler M.D. | | DEGREE
M.D. | 22c. DATE SIGNED
Dec 31, 1987 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE TALER, M.D. | | 22e. ADDRESS
600 LIGHT ST BALTIMORE, MD. 21230 | |

| | | | |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
1/4/1988 | 23c. NAME OF CEMETERY OR CREMATORY
CARRISON FOREST YET CEM | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. |
| 24. FUNERAL HOME
NAME ADDRESS
NUTTER FUNERAL HOMES, INC.
2501 GWYNNS FALLS PKWY, BALTO. MD. 21216 | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1988 | 25b. REGISTRAR'S SIGNATURE
J. J. Anderson |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top part. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (b) be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ESTHER EVANS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/28/87 | | 2b. HOUR
1430 PM | | |
| 3. SEX
F | | 4. RACE
B 2 | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 4 90 | | | |
| 6. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
SC | | 7a. CITIZEN OF WHAT COUNTRY?
7b. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 6. AGE (IN YEARS LAST BIRTHDAY)
97
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 74 HRS. HOURS MIN. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS ZIP CODE
1276 Beaumont Ave 21239 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Pinnery | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Nellie | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
083-16-7356 | | 17. INFORMANT
ADDRESS
Gladys Cannon 1276 Beaumont Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) anoxia
DUE TO, OR AS A CONSEQUENCE OF
(b) myocardial failure, S/PCPR
DUE TO, OR AS A CONSEQUENCE OF
(c) myocardial arrest | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 days
6 days
6 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
valvular insufficiency of heart | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> N/A NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
N/A | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
N/A | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
N/A | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21/87, 19 87, to 12/28, 19 87, that (I) (we) last saw the deceased alive on 12/28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. Smirnow | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Smirnow | | | | 22e. ADDRESS
Union Mem Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(IF BY) | | 23b. DATE
1/2/88 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD 21207 | |
| 24. FUNERAL DIRECTOR
NAME
Thasman A. King 6367 p/mur st | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | 25b. REGISTRAR'S SIGNATURE
John L. ... | |

BP

V

1347

Y 02 1 5-2420-1

DEC 3 8 1971

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
FREDDIE J. EVANS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 1 87 | | | 2b. HOUR
11:15 AM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 10 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS)
BOILER MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
LINTHICUM | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM FRED EVANS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
REBA RATLIFF | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
WW II 232-40-3757 | |
| 17. INFORMANT
KATHERINE EVANS | | 18. ADDRESS
19 HAMPTON RD. 21090 | | 19. STREET ADDRESS / ZIP CODE
19 HAMPTON ROAD 21090 | | 20. MOTHER'S MAIDEN NAME
REBA RATLIFF | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESP. ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>LIVER CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Acute Hepatic Failure</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Acute Renal Failure</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | 21d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 21e. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21g. LOCATION
CITY OR TOWN COUNTY STATE | | 21h. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>11/28</u> , 19 <u>87</u> , to <u>12/1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE IN FULL)
<i>Rony Vorodimsky</i> | | 22e. ADDRESS
3001 S. HANOVER ST. BALTIMORE | | 22f. ADDRESS | | 22g. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL CEM. BALTIMORE | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | 24b. ADDRESS
21229
4107 WILKENS AVE. | | 25. DATE REC'D BY REGISTRAR
DEC - 4 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

1741 DEC-7-61

RECEIVED



DEC-4-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Assunta | | MIDDLE Furnow | | LAST Furnow | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/23/87 | | 2b. HOUR
4:35 A | |
| 3 SEX Female | | 4 RACE WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 - 18 - 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
--- -- -- -- | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
406 S. EXETER ST. BALTO. 21202 | |
| 14. FATHER'S NAME
FIRST LOUIS LAST IANNANTUONO | | 15. MOTHER'S MAIDEN NAME
FIRST THOMASINA MIDDLE UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO.
243-12-0313D | | 17. INFORMANT
ADDRESS
Jane Giardino 406 S. Exeter St. Balto. 21202 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lipo sarcoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
WES | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12/23 8:15 P.M. 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
12/23 87 | | CITY OR TOWN
12/23 87 | | COUNTY
12/23 87 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23 87 to 12/23 87 that (I) (we) saw the deceased alive on 12/23 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
H Joseph Kim M.D. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H JOSEPH Kim | | 22e. ADDRESS
Mercy Hospital, Balto MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem. | | 23d. LOCATION
CITY OR TOWN
Baltimore, Maryland | | COUNTY
Baltimore | |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler Inc. | | ADDRESS
1901 Eastern Ave | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1987 | | 25b. REGISTRAR'S SIGNATURE
Jane Barker-Rodman | | | |

7

10/21/64

Mr. J. Edgar Hoover

Director

Washington, D.C.

Dear Sir:

Enclosed

is a copy of the

Report

Very truly yours,

W. J. Rorick

x

Special Agent

in Charge

File # 100-441111-100

075913 DEC 23 1987

Item 23c,d, G639 5-3-88 dw

FOR per MD. Vet. Comm.

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

4 6 3 9

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|--|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Robert R Fauntleroy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 20 87 | | | 2b. HOUR
0856 M | | | | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 21 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. INDUSTRY OR BUSINESS
PAINT CO. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
BALTIMORE, MD.
1301 WINCHESTER ST. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES FAUNTLEROY | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY E. FLOWERS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT MRS. ADDRESS BALTO, MD. 21217
ANNA MAE FAUNTLEROY 1301 WINCHESTER ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Electromechanical dissociation
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Urosepsis | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/19/87 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute thrombosis Right leg | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21i. LOCATION
STREET
22 S Greene St | | CITY OR TOWN
BALTIMORE | | STATE
MD. |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 87 , to 12/20 , 19 87 , that (I) (we) last saw the deceased alive on 12/20 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Lawrence E. Kass | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/20/87 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Lawrence E. Kass | | | | | 22e. ADDRESS
22 S Greene St | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
12/24/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest V.A. Cem. | | | 23d. LOCATION
CITY OR TOWN OWINGS MILLS, BALTIMORE, MD. COUNTY BALTIMORE STATE MD. | | |
| 24. FUNERAL HOME, INC.
2501 GWYNNS FALLS PKWY. BALTO, MD. 21216 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1987 | | | 25b. REGISTRAR'S SIGNATURE
John D. Anderson | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of force.

BP

10/10/10

10/10/10

10/10/10

10/10/10



078192 JAN 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1, 2 and 3. Carbon 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| FOR STATE REGISTRAR | | | | REG. NO. 34640 | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Joseph Fedeli | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-21-87 | |
| 3. SEX
MALE | | 4. RACE
CAU | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 22 1897 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 8. CITIZEN OF WHAT COUNTRY?
USA | |
| 9. CITY OR TOWN OF DEATH
BALTO | | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
414 S. EDEN ST. | | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTO MD. | |
| 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)
Factory worker | | 12b. KIND OF BUSINESS OR INDUSTRY
PLASTICS | | 13. STREET ADDRESS / ZIP CODE
414 S. EDEN ST 21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANGELO FEDELI | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16. SOCIAL SECURITY NO.
212-09-6387 | |
| 17. INFORMANT
NAME ADDRESS
LINA FEDELI 414 S. EDEN ST. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
(1) Cerebral Vascular Accident with (2) Hemiparesis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from Nov 13 87 to Dec 21 87 that (1) (we) last saw the deceased alive on Nov 13 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Neal M. Friedlander, MD | | | | 22c. DATE SIGNED
12/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NEAL M. FRIEDLANDER, MD | | | | 22e. ADDRESS
333 ST. PAUL PLACE, SUITE 2A BALTIMORE MD, 21202 | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)
BURIAL | | 23b. DATE
12-23-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park | |
| 24. FUNERAL DIRECTOR
NAME
Frank Rich Place | | ADDRESS
322 S. HIGH ST. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Friedman | |

074144 DEC - 7 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34641

| | | | | | | |
|---|--|---|--|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Gertrude M. Fegelein | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 3, 1987 | | 2b. HOUR
11:30A M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 16 15 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1014 S. Clinton Street | | 12b. KIND OF BUSINESS OR INDUSTRY
Food | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Andrew Fegelein | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Piasecki | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-05-1692 | | 17. INFORMANT
ADDRESS
Miss Josephine Fegelein, 1014 S. Clinton St.
Baltimore, Md. 21224 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic ovarian cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> , 19 <u>87</u> , to _____, 19____, that (I) (we) last saw the deceased alive on <u>12/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Debra G. Carlton, MD</u> DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12/3/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Debra G. Carlton</u> | | | | 22e. ADDRESS
<u>3411 Bank St
Baltimore, Md. 21224</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-7-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus Cemetery | | |
| 24. FUNERAL DIRECTOR
Ann S. Matthews, Matthews Funeral Home
3021 Eastern Ave., Baltimore, Md. 21224 | | 25a. DATE REC'D. BY REGISTRAR
DEC - 4 1987 | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | |



10-10-11 11:11

10-10-11 11:11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

87 REG. NO. 34642

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WORMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 25 87 | | | 2b. HOUR
PM | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 07 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland
XXXXX | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GEN HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RAILWAY | | 12b. KIND OF BUSINESS OR INDUSTRY
RAILWAY | |

| | | | | | | | | |
|---|--|--|---|---------------------------------|--|--|-----------------------------|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
3511 GORDMAN AVE 21213 | | |
| 13a. STATE
MD | | 13b. COUNTY
XXXXXX | | 13c. CITY OR TOWN
BALT | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANDREW FEIG | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA ANDREWS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
XXXXX No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
714105929 | | 17. INFORMANT
CATHERINE FEIG | | | ADDRESS
3511 GORDMAN AVE | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>2 1/2 Hours</u> | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ASPIRATION PNEUMONIA</u> | | <u>2 one day</u> | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>UROSEPSIS</u> | | <u>8 days</u> | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>87</u> to <u>12/25</u> 19 <u>87</u> , that (I) (we) lost
saw the deceased alive on <u>12/25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>A. P. Mansbury MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/25/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>A. P. MANSBURY MD</u> | | | | 22e. ADDRESS
<u>3001 S. Hanover St Balt Md 21230</u> | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 28, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | |
| 24. FUNERAL DIRECTOR
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Baltimore, Md. 21214 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Al. Davidson-Randall</u> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

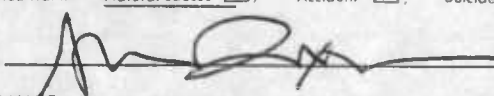

1606370 102081

2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

1606370 102081

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **34643**

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|---|--|---|--|--|----------------------------|--|----------------------------|--|--|---|--|---|--|--|--|-------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILSON | | | | | | | | | | 2. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 16 19 87 | | | | | | | | | | 7b HOUR 8:51 A M | |
| 3 SEX MALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 03-06-19 | | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD 12 16 19 87 | | | 7d HOUR 8:51 A M | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) SUMTER, S.C. | | | | 7b CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 911 Leadenhall St. | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a STATE MARYLAND | | | | | | | | | | 13b COUNTY BALTIMORE | | 13c CITY OR TOWN BALTIMORE | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 911 LEADENHALL ST. APT. 411 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LAWRENCE FELDER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA MAGWOOD | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 248-10-9915 | | | | 17. INFORMANT ADDRESS FANNIE FELDER 911 LEADENHALL ST. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) Deputy Chief M.D. | | | | MEDICAL EXAMINER | | | | DATE SIGNED 12-16-87 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 12-20-87 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS BROWN/THOMPSON F.H. P.O. BOX 4433 (21223) | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 18 1987 | | | 25b. REGISTRAR'S SIGNATURE  | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

100-100000

100-100000

[Handwritten signature]

075636 DEC 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 3 4 6 4 4
REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SALVATORE A. FELICETTI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 16 / 87 | | 2b. HOUR
1090 PM |
| 3. SEX
MALE | 4. RACE
CAU. | 5. DATE OF BIRTH
MONTH DAY YEAR
6 26 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNUS | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor/Ret G+E | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
538 Lucia Ave 21224 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANTHONY Felicetti | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace Lombardi | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | 16b. SOCIAL SECURITY NO.
213-43960 | 17. INFORMANT
ADDRESS
BARBARA Felicetti 538 Lucia Ave 21224 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute MI
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CAD
DUE TO, OR AS A CONSEQUENCE OF
(c) ABSCVD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
Year
Year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 51 19 81 to 12/16 19 87 , that (I) (we) last saw the deceased alive on 8/11 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-19-87 | 23c. NAME OF CEMETERY OR CREMATORY
Louisa Park | | 23d. LOCATION
OR TOWN COUNTY STATE
BALTO MD. |
| 24. FUNERAL DIRECTOR
NAME
Samuel DeLoe | | ADDRESS
322 S. H. St | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1987 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

MEDICAL CERTIFICATION

99

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Am.

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

10121 83370

07863

074823 DEC 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34645

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN FELLE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 07 87 | | | 2b. HOUR
4:15 PM | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 27 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LIBERTY MEDICAL HGTS. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3413 SPRINGDALE AVE. 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
229-20-2795 | | 17. INFORMANT
ADDRESS
CHART - LIBERTY MEDICAL CENTER | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF NECK
(b) CARCINOMA WOUND WITH METASTASIS.
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
LEIOMYOMA VASCULAR DISEASE, SEIZURE DISORDER

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-18-1987 to 12-7-1987 , that (I) (we) last saw the deceased alive on 12-7-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Sudhir D. Patel | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-7-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUDHIR D. PATEL | | | | 22e. ADDRESS
LIBERTY MEDICAL CENTRE
LIBERTY HEIGHTS. BALTIMORE. | | | |

| | | | | | | | |
|--|--|------------------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-10-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1987 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Friedman | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

074874 DEC 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34646

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
PILAR Berges FERNANDEZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 2 87 | | | 2b. HOUR
10:10 P. | |
| 3. SEX
F | | 4. RACE
Hispanic | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 12 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SPAIN | | 7b. CITIZEN OF WHAT COUNTRY?
CUBA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MOUNT VERNON NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MARIANO BERGES | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
TERESA MORTE | | 16. STREET ADDRESS / ZIP CODE
10100 New Hampshire Ave. 20903 | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
X | | 17b. SOCIAL SECURITY NO.
215-74-9060 | | 17. INFORMANT
Son
Luis Fernandez
ADDRESS
884 Diamond Drive Gaithersburg, Md. 20878 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 3
DUE TO, OR AS A CONSEQUENCE OF (c) 3 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
9 3 87 12-1-87 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-1-87 to 12-1-87 , that (I) (we) last saw the deceased alive on 12-1-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
ASHOK K Chatterjee | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-3-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ASHOK K Chatterjee | | 22e. ADDRESS
3927 ANNAPOLIS LANE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 5, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md. 20901 | | | | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers #1, #2, and #3 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

10-21-2011 10:50:50

3754

X

076677 DEC 31

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 3 4 6 4 7

| | | | | | | | | | |
|---|--|--|--|--|------------------------------------|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MOLLIE D. FERRERI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-27-87 | | | 2b. HOUR
1:55 A.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
03/22/007 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
95 90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ralph Ditullio | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
? | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | |
| 16b. SOCIAL SECURITY NO.
212-01-3743D
218-13-9291 | | | 17. INFORMANT
ADDRESS
227 Worthmont Rd.-Balto., Md.
Mr. Frank S. Ferreri #21228 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
0-2 min.
Several days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Renal failure, Cerebral Vascular Accident. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/20 , 19 87 , to 12/27 , 19 87 , that (I) (we) lost saw the deceased alive on 12/27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Timothy D. Nichols | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Timothy D. Nichols | | | | 22e. ADDRESS
900 CITON AVE. Baltimore, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 30, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
G. KRUMAN SUTWAB | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1987 | | 25b. REGISTRAR'S SIGNATURE
David R. Riddle | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

17-10-10

DEC 30 1947

075267 DEC 16 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 34648

| | | | |
|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Blanche Fetsch | | 2a. DATE OF DEATH
MONTH 12 DAY 09 YEAR 87 HOUR 04:28 M | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH 05 DAY 09 YEAR 12 | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Agnes Hospital | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Occup. Therapist | 12b. KIND OF BUSINESS OR INDUSTRY
Health |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Catonsville |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph E. Countess | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Roberta Lee | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | |
| 17. INFORMANT
Pamela Fetsch | | ADDRESS
Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Several Years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<u>Insulin Dependent Diabetes Mellitus, Anemia, Renal Insufficiency</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/20/87</u> , 19____, to <u>12/9/87</u> , 19____, that (I) (we) lost saw the deceased alive on <u>12/9/87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Timothy D. Nichols</u> | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
12/9/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Timothy D. Nichols, M. D. | | 22e. ADDRESS
900 Caton Avenue, Balto. MD 21229 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12/14/87 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City MD |
| 24. FUNERAL DIRECTOR
NAME
MacNabb Funeral Home, Catonsville, MD | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1987 | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

012505 DEC 1983

075772 DEC

FOR
587
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 6 4 9
REG. NO.

| | | | | | | | | | | | |
|---|---------|------------------|--|---|---------------------|---|--|---|---------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF DEATH | | | 2c. HOUR | | |
| Russell M. Feuerhardt | | | 12/ 4/ 87 | | | 12/ 4/ 87 | | | 6:25 a.m. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | | | 10. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Male | Cauc. | 1 1 1956 | 31 YRS. | | | 12/ 4/ 87 | | | Baltimore City, MD | | |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 12. CITIZEN OF WHAT COUNTRY? | | | 13. MARRIED | | | 14. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | | | U.S.A. | | | NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Baltimore City, MD | | |
| 15. CITY OR TOWN OF DEATH | | | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 18. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | 601 N. Linwood Ave. | | | Unemployed | | | | | |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 20. STATE | | | 21. COUNTY | | | 22. CITY OR TOWN | | | 23. STREET ADDRESS | | |
| Md. | | | | | | Baltimore | | | 601 N. Linwood Ave. 21205 | | |
| 24. FATHER'S NAME | | | | | | 25. MOTHER'S MAIDEN NAME | | | | | |
| George Feuerhardt | | | | | | Marilyn Jones | | | | | |
| 26. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | 27. SOCIAL SECURITY NO. | | | | | |
| No | | | | | | | | | | | |
| 28. INFORMATION | | | | | | 29. ADDRESS | | | | | |
| Marilyn Harper | | | | | | 601 N. Linwood Avv | | | | | |
| 30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | |
| Cirrhosis of Liver | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Chronic Alcoholism | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 31a. DATE OF OPERATION | | | | 31b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 32. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 33a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 33b. TIME OF INJURY | | | | 33c. HOW INJURY OCCURRED | | | |
| | | | | P.M. 19 | | | | ENTER NATURE OF INJURY IN USM 18 PART 1 OR PART 2 | | | |
| 34a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 34b. PLACE OF INJURY | | | | 34c. LOCATION | | | |
| | | | | STREET, FACTORY, FARM, ETC. | | | | CITY OR TOWN COUNTY STATE | | | |
| 35. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| 36. ACTUAL SIGNATURE | | | | | | 37. DATE SIGNED | | | | | |
| Dennis F. Smyth, M.D. | | | | | | 12/4/87 | | | | | |
| 38. EXAMINER'S NAME | | | | | | 39. ADDRESS | | | | | |
| Dennis F. Smyth, M.D. | | | | | | 111 Penn St., Balto., Md. 21201 | | | | | |
| 40. BURIAL, CREMATION, REMOVAL | | | | 41. DATE | | | | 42. NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | | 12/7/87 | | | | Oak Lawn Cem. | | | |
| 43. FUNERAL DIRECTOR | | | | 44. DATE REC'D. BY REGISTRAR | | | | 45. REGISTRAR'S SIGNATURE | | | |
| B. Dabrowski & Son 2818 E. Baltimore St. | | | | DEC 16 1987 | | | | Dennis F. Smyth | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1001. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

052115 050505

20% COTTON FIBER

WINDMILL BRAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 34650 | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE M. Finan | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-5-87 2b. HOUR 10⁴⁵ PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 04 22 09 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Baltimore, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retire | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE 633 Harvey St, Bkts MD. 21230 | |
| 13a. STATE MARYLAND | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Maryland | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George A. Finan | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Korb | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 215017558 | |
| 17. INFORMANT ADDRESS Shirley A. Zemke, 310 W. Arden Rd. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF Lung
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Lung CA with Metastasis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 11-3- 19 87 to 12-05- 19 87 , that (we) lost saw the deceased alive on 12-05- 19 87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (direct) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE M.D. | | 22c. DATE SIGNED 12-05-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMAE/FULE | | 22e. ADDRESS SBCGH | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/9/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cent. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. A.A. Co. Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC-7 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

BP

07310 DEC 09

DEC - 1 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|-----------------------------|
| 1. FOR STATE REGISTRAR | | | | | 7 3 4 6 5 1
REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
87 MELVIN J FINK | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 3 87 | | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JULY 18, 1909 | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 YRS | | 2b. HOUR
10:40 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
MUSICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
MUSIC | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2224 PARK AVE. #21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JACOB FINK | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
BEULAH STAYLOR | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII-NAVY | | 17. INFORMANT
MRS. FRIEDA W. FINK | | ADDRESS
2224 PARK AVE. BALTO., MD | | 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>QUINOLIC TABLETS</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>HYPERKALEMIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>METASTATIC CANCER OF UNKNOWN SOURCE</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> 19 <u>87</u> to <u>12/3</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>L. Llewellyn I. Kitchen</i> | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/3/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LLEWELLYN I. KITCHIN M.D. | | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
DEC. 6, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia B. ...</i> | | |

BP

74505 DEC 11 07

DEC 10 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Jerome Or Jerry Ashbein

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

12/11/87

4A M

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

1 6 21

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN.

YRS

66

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

SINAI HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

MERCHANT

12b. KIND OF BUSINESS OR INDUSTRY

RETAIL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

BALTO.

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE

23 STONEHENGE CIR. #21208

14. FATHER'S NAME

LOUIS

MIDDLE

FISHBEIN

15. MOTHER'S MAIDEN NAME

SARAH

MIDDLE

LOMONOSOFF

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

YES

(IF YES, GIVE WAR OR DATES)

WWII-ARMY

16b. SOCIAL SECURITY NO.

215-14-8426

17. INFORMANT

MRS. DOROTHEA FISHBEIN

23 stonehenge cir., apt. 12 #21208

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Immune compromise / Multiple Myeloma

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/10/87 to 12/11/87, that (I) (we) lost

above, (I) (we) did not view the body after death.

22b. SIGNATURE

[Signature]

DEGREE

MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/11/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. Blotnapar

22e. ADDRESS

Sinai Hospital, Baltimore

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

DEC. 13, 1987

23c. NAME OF CEMETERY OR CREMATORY

BETH EL MEM. PARK

23d. LOCATION

RANDALLSTOWN

BALTO.

MD

24. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC.

6010 REISTERSTOWN RD. BALTO., MD

21215

25a. DATE REC'D. BY REGISTRAR

DEC 15 1987

25b. REGISTRAR'S SIGNATURE

[Signature]

073139 NOV 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 4653

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KENNETH Stanley FISHER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
NOVEMBER 17, 1987 | | 2b. HOUR
10:45 ^A |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 7, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS | IF UNDER 1 YEAR
MONTHS DAYS
11 10 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. Airforce | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | | 13b. COUNTY
Carroll | 13c. CITY OR TOWN
Mt. Airy | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Ezea Fisher | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Blance Viola Poulson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1948-1972 | 17. INFORMANT
ADDRESS
Effie I. Fisher, Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>CIRRHOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ALCOHOLISM</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK
1 YR
30 YR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>SALMONELLA INFECTION. NON-A NON-B HEPATITIS</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> 19 <u>87</u> , to <u>11/17</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Howard Baum</u> | | DEGREE
MD | | 22c. DATE SIGNED
11/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HOWARD BAUM | | 22e. ADDRESS
JH H | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
11-19-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Taylorsville | |
| 23d. LOCATION
CITY OR TOWN | | 23e. COUNTY
Carroll, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Charles W. Burrier, Jr., Sykesville, Md. | | 25a. DATE REC'D. BY REGISTRAR
NOV 19 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | |

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been given by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be signed by a medical examiner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 8 7 3 4 6 5 4 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | |
| Mary Lu FitzSimons | | | | | | FitzSimons | | MONTH DAY YEAR HOUR | |
| 6 87 | | | | | | | | 12 5 87 9:00 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Female | | White | | December 22, 1910 | | 76 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| Maryland | | U.S.A. | | | | Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Union Memorial Hospital | | Homemaker | | --- | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | --- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 204 Paddington Road 21212 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Adolph | | Lucy Morton Jones | | No | | 220-46-7175 | | A.M. FitzSimons 204 Paddington Road 21212 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Cardiopulmonary Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | Cerebrovascular Accident | | 72 hours | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | Myocardial Infarction | | 280 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | ACSD, HTN | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 12/1/87 | | Pelvic Gyn / Mass | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 12/1/87 | | 12/5/87 | | 12/5/87 | | that (I) (we) last saw the deceased alive on | |
| above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Andrew M. Baer, M.D. | | | | | | 12/5/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Andrew M. Baer, md. | | Union Memorial Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN COUNTY STATE | |
| Entombment | | 12-9-87 | | Dunlany Valley Maus. | | Lutherville Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Mitchell-Wiedefeld Home 6500 York Road 21212 | | DEC 15 1987 | | John Swindler | | | | | |

BP

0751 20 10 18 87

1887

1887

1887

1887

1887

1887

1887

073092 NOV 25 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34655

FOR REGISTRATION
Item 13C
12-17-87 A.L.
Phone #

| | | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
(Mabel) Mable C. Foote | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11 19 1987 | | | 2b. HOUR
M | | | | | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 17 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 6. AGE (IN YEARS LAST BIRTHDAY)
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1808 Madison Ave. 21217 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
N/A | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
N/A | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
217 -05-2876 | | |
| 17. INFORMANT
ADDRESS
Terri R. Gray 3916 Liberty Heights | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute WA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thromboembolic
DUE TO, OR AS A CONSEQUENCE OF (c) Secondary ulcers | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. Anna Johnson | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARSHA J. Brown, MD | | | | | | 22e. ADDRESS
844 Ch. Carey St. 21217 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
11/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Auburn Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H West 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 24 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

13005

075535 DEC 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG NO. 34653

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST JACK MIDDLE LAST FORHMAN
JACK FORHMAN | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 15 87 | | 2b. HOUR
5:20 A M | |
| 3. SEX
male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 30 1898 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Levindale HEBREW HOME | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | |
| 14. FATHER'S NAME
FIRST UNKNOWN MIDDLE LAST FORHMAN | | 15. MOTHER'S MAIDEN NAME
FIRST IDA MIDDLE LAST UNKNOWN | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Auto mechanic | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-30-0807 | | 17. INFORMANT
MRS. HARRIET SIDLE APT. 106
4145 EXPRESS REACH CT. POMPANO BEA, FL 33069 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fluid and electrolyte imbalance
DUE TO, OR AS A CONSEQUENCE OF
(b) Urinary tract Infection & G-I bleed
DUE TO, OR AS A CONSEQUENCE OF
(c) S/P (L) CVA with (R) Hemiparesis

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8:20, 19 87, to 12:15, 19 87, that (I) (we) last saw the deceased alive on 12 14 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
E. G. G. W. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SET H TWAH | | 22e. ADDRESS
Levindale - 2434 W. Belvidere Ave
Baltimore, Md. 21215 | | | | | |

| | | | | | | | |
|---|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 16, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP | | 23d. LOCATION
CITY BALTIMORE COUNTY MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper's page 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

075114 DEC 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 6 5 7

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Bruce Douglas Forster | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-9-87 | | | | 2b. HOUR
114M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 31 62 | | 6. AGE (IN YEARS LAST BIRTHDAY)
25 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS
25 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mason F. Lord Bldg. | | | | 12a. USUAL OCCUPATION
(TYPE WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2322 Searles Road 21222 | | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
William Forster | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANGELINA RASPA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-92-2357 | | 17. INFORMANT
ADDRESS
MRS. ANGELINA FORSTER
2322 Searles Road, Baltimore MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
9299
DUE TO, OR AS A CONSEQUENCE OF Seizure Disorder
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b)
DUE TO, OR AS A CONSEQUENCE OF Head Trauma
(c) 23 yrs.
23 yrs. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
C. Difficile diarrhea | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
5200 Eastern Ave | | CITY OR TOWN
BALTIMORE | | COUNTY
BALTIMORE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) _____ the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W.B. Greenough | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W.B. Greenough | | | | 22e. ADDRESS
5200 Eastern Ave BALT. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-12-87 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLLY HILL MEM. GAR | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR
NAME
ANN S. MATTHEWS MATTHEWS FUNERAL HOME | | | | 25a. DATE REC'D BY REGISTRAR
DEC 15 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| 25c. ADDRESS
3021 Eastern Avenue, Baltimore, MD. | | | | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. The purpose of this report is to provide a summary of the results of the investigation conducted during the period from 1 January 1963 to 31 December 1963. The investigation was conducted in accordance with the instructions of the Joint Chiefs of Staff, Department of Defense, and the Joint Staff, Joint Chiefs of Staff, Department of Defense.

2. The investigation was conducted by the Joint Staff, Joint Chiefs of Staff, Department of Defense, and the Joint Staff, Joint Chiefs of Staff, Department of Defense. The investigation was conducted in accordance with the instructions of the Joint Chiefs of Staff, Department of Defense, and the Joint Staff, Joint Chiefs of Staff, Department of Defense.

3. The investigation was conducted by the Joint Staff, Joint Chiefs of Staff, Department of Defense, and the Joint Staff, Joint Chiefs of Staff, Department of Defense. The investigation was conducted in accordance with the instructions of the Joint Chiefs of Staff, Department of Defense, and the Joint Staff, Joint Chiefs of Staff, Department of Defense.

4. The investigation was conducted by the Joint Staff, Joint Chiefs of Staff, Department of Defense, and the Joint Staff, Joint Chiefs of Staff, Department of Defense. The investigation was conducted in accordance with the instructions of the Joint Chiefs of Staff, Department of Defense, and the Joint Staff, Joint Chiefs of Staff, Department of Defense.

W. B. C. 1963
W. B. C. 1963
W. B. C. 1963


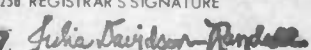
Film G635 item 18-22a

FOR
STATE
7 REGISTRAR

1/12/88 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 4 6 5 8

| | | | | | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Brenda | | MIDDLE
Lynn | | LAST
Foster | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR XX 12-1 19 87 | | 2b. HOUR
5:44 p.m. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 2, 1962 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
25 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS
12-2 19 87 | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-2 19 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6896 McClean Boulevard | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Never worked | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6896 McClean Blvd. 21234 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David V. Foster | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ann Elizabeth Ferguson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
218-72-0360 | | 17. INFORMANT ADDRESS
David V. Foster -143 Othoridge Rd. 21093 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: <u>Propoxyphene and alcohol intoxication</u>
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 12/2/87 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject took drugs and alcohol | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6896 McClean Blvd. Baltimore City Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
12-3-87 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Entombment | | 23b. DATE
12-5-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Maus. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville, Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc., Towson, Md. 21204 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 08 1987 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

NOTE TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE COMPLETE AND RETURN THIS CERTIFICATE TO THE CHIEF MEDICAL EXAMINER WITHIN 72 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 WEST PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

DHMH - 17
(VR A15 ME (5))

20% COTTON FIBER

DAVID WINSTON



074433 DEC

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34659
REG. NO.

| | | | | | | | | |
|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(Type in print)
FIRST MIDDLE LAST
FRANK FOSTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/3/87 | | 2b. HOUR
MIN.
12³⁰ AM | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3/2/18 | | 6. AGE (in years last birthday)
69 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
V.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(If not in such facility, give street address)
Loch Raven VA Hospital | | 12a. USUAL OCCUPATION
(Type of work for most of working life)
Labor | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIE FOSTER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HELEN DAVIS | | 13e. STREET ADDRESS / ZIP CODE
201 N. Washington St. #212/13 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | 16b. SOCIAL SECURITY NO.
213092133 | | 17. INFORMANT (SISTER) ADDRESS
Ada F. Epps 1300 E. LANVALE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) End Stage Renal Disease
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from Dec 1, 1987 , to Dec 3, 1987 , that (I) (we) last saw the deceased alive on Dec 3, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Jeffrey Joe MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12-3-87 | | |
| 22d. PHYSICIAN'S NAME (Type in print)
Jeffrey Joe MD | | | | 22e. ADDRESS
225 Greenbelt, Baltimore, MD 21201 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
12/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
BARTO NAT. Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Betts Funeral Home 1844 Caroline St | | | | 25a. DATE RECEIVED BY REGISTRAR
DEC - 7 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

01443 DEC-61

DEC-3 1961

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

8 7 REG. NO. 3 4 6 6 0

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--------------------------------------|--|-------------------------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| DOROTHY A. FOX | | | | | | | | 12/5/87 | | | | | | | | 1:15 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. BALTIMORE CITY | | 11. BALTIMORE CITY | |
| F | | W | | 06 01 14 | | 76 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. BALTIMORE CITY | | 11. BALTIMORE CITY | | 12. BALTIMORE CITY | | 13. BALTIMORE CITY | | 14. BALTIMORE CITY | |
| MD | | USA | | | | Baltimore City | | Baltimore City | | Baltimore City | | Baltimore City | | Baltimore City | | Baltimore City | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | | 13e. CITY OR TOWN | |
| BALTIMORE | | North Charles General | | Housewife | | | | 807 Union Avenue 21211 | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 807 Union Avenue 21211 | | Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | | EMPHYSEMA & RESPIRATORY FAILURE | |
| Blaney | | (unknown) | | No | | 212 07 9952 | | Patricia Mixter 23 BonBon Ct. 21136 | | EMPHYSEMA & RESPIRATORY FAILURE | | | | | | | |

051304 00-301

ON LABEL

15-1-1971 18:00 18:30

15-1-1971 18:00 18:30

15-1-1971 18:00 18:30

15-1-1971 18:00 18:30

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3466
REG NO

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
FRANK | | MIDDLE | | LAST
FOX | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 12 1987 | | 2b. HOUR
M 12:12 PM | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR 1 14 1929 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 58 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 12 12 1987 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Alabama | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3821 Garrison Blvd 21215 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charlie Fox | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie Boggs | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
421-20-5450 | | 17. INFORMANT
Brenda Bellamy | | ADDRESS
4726 Pimlico Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | M.D. <u>Ann M. Dixon, M.D.</u> | | | | TITLE (SPECIFY)
Deputy Chief | | MEDICAL EXAMINER | | DATE SIGNED
12-13-87 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Auburn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H West 4300 Wabash Avenue | | | | | | 25. DATE REC'D BY REGISTRAR
DEC 15 1987 | | 26. REGISTRAR'S SIGNATURE
Julia Gordon-Lindner | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE DELAY. AFTER DEATH, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 101 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

DHMH - 17
(VR A15 ME (5))

012100 6X06

012100 6X06

Handwritten signature

012100 6X06

075533 DEC 21

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 4662

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY LOUISE FRANCO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-16-87 | | | 2b. HOUR
2:30 PM | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
1-4-1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY - MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3009 OAKCREST AVE. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
MD. | | 13b. COUNTY
— | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3009 OAKCREST AVE. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALLORO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SEBASTIANNA | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | |
| 16a. SOCIAL SECURITY NO.
219-05-5027 | | 17. INFORMANT
ADDRESS
Mrs. Anna O. Detrie - 3009 Oakcrest Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary heart failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) MSCVD
DUE TO, OR AS A CONSEQUENCE OF
(c) —
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
one week
1976 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Pericious anemia | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
— P.M. 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from May 82 to Dec 87 , that (1) we lost
saw the deceased alive on Dec 15 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (1) we (1) did (1) did not view the body after death. | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles M. Kerr MD | | 22c. ADDRESS
6801 Belair Rd 21206 | | 22d. DATE SIGNED
Dec 18, 87 | | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-19-87 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO., MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
Janet H. Giddens | | 24b. ADDRESS
7527 Warford Rd. | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Hendall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP

X

12-16-87

MARY LOUISE FRANCO

PS

1-M-1892

W

F

BALTIMORE CITY -

X

U.S.A.

ITALY

HOMERAKER HOME
21234

3000 CARQUEST AVE

BALTO.

3000 CARQUEST AVE

X

BALTO

MD

SEBASTIAN

ALORD

11-25-87 11-25-87 11-25-87

NO

11-25-87

11-25-87

11-25-87

11-25-87



COX COLLOD

BURIAL 12-17-87 HOW REDEMER BOLE 110

NI

11-25-87 11-25-87 11-25-87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

WALTER

FRANCZKOWSKI

3. DATE OF DEATH MONTH DAY YEAR
DECEMBER 14, 1987

2b HOUR

3:35 PM

3. SEX

M

4. RACE

Cauc

5. DATE OF BIRTH

5 14 1923

6. AGE (IN YEARS LAST BIRTHDAY)

64

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY) Md

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City

MD.

10. CITY OR TOWN OF DEATH
Balto

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk

12b. KIND OF BUSINESS OR
INDUSTRY
Koppers Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

13c. CITY OR TOWN

Balto

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

121 Rochester Pl 21224

14. FATHER'S NAME

FIRST

Peter

MIDDLE

LAST

Franczkowski

15. MOTHER'S MAIDEN NAME

FIRST

Julia

MIDDLE

LAST

Dudek

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

216-14-7171

17. INFORMANT

121 Rochester Pl. 21224
Mrs. Alexandra Franczkowski

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

ACUTE RESPIRATORY JONHIERE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) PANCOST LUNG TUMOR WITH METS

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from DEC. 9, 19 87, to DEC. 14, 19 87, that (I) (we) last saw the deceased alive on DEC. 14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

BEENA NAJPAL

22e. ADDRESS

CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)
Burial

23b. DATE

12/18/87

23c. NAME OF CEMETERY OR CREMATORY

Holy Rosary Cem.

23d. LOCATION

CITY OR TOWN

Balto

COUNTY

STATE

Md

24. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto St

21224

25a. DATE REC'D. BY REGISTRAR

DEC 17 1987

25b. REGISTRAR'S SIGNATURE

Julia Anderson-Randall

076026 DEC 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 6 6 4

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Marianna (Frascketti) Frasketti

2a. DATE OF DEATH

MONTH

DAY

YEAR

12 19 87

2b. HOUR

8:08^P_M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

1-24-1988

6. AGE (IN YEARS LAST BIRTHDAY)

99

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

Italy

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Church Hospital

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR
INDUSTRY

None

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Baltimore

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS

3412 E. Pratt St. 21224

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Frankina

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

236-48-5522

17. INFORMANT

ADDRESS

Salvatore Frascoketti 8215 No Boundary Rd. 21222

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

C.V.A.

DUE TO, OR AS A CONSEQUENCE OF

A.S.C.V.D.

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

A.R. Nazemi M.D.

DEGREE

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☒

22c. DATE SIGNED

12/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

A.R. Nazemi, M.D.

22e. ADDRESS

Church Hospital

100 N. Broadway, Baltimore, Md. 21231

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12-23-87

23c. NAME OF CEMETERY OR CREMATORY

Sacred Heart of Jesus

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Baltimore

Md.

24. FUNERAL DIRECTOR

NAME

LANNINO F.H.

ADDRESS

263 S. Conkling St. 21224

25a. DATE REC'D. BY REGISTRAR

DEC 22 1987

25b. REGISTRAR'S SIGNATURE

[Signature]

BP

DHMH-1650M/1-BI
(VRA 15, 4)

(continued)

WESTED 11/20/70

ph

1

11/20/70

074838 DEC 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|--------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE FRAZIER LAST | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 8, 1987 | | 2b. HOUR
9:45 P | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 12 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOME HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13e. STREET ADDRESS / ZIP CODE
1215 YOUNG COURT 21202 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM FISHER | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-01-7912 | | 17. INFORMANT
ADDRESS
HOWARD GANS 1215 YOUNG COURT 21202 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>BLEEDING STOMACH TUMOUR</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC. 06</u> , 19 <u>87</u> , to <u>DEC 8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>DEC 8</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>R. Spina M.D.</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
_____ | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNE ARUNDEL CO. MD | | | |
| 24. FUNERAL DIRECTOR
NAME
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | 25. DATE REC'D. BY REGISTRAR
DEC 11 1987 | | | | | |

BP _____

DHMH - 16 60M 7/84
(VRA 15. 4)

076981 JAN 15 1988

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 3 4 6 6 6
REG. NO.

| | | | | | | | |
|--|--|--|--|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Beulah Beatrice Frederick | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 31 87 | | 2b. HOUR
6:30 PM | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 17 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS HOURS MIN.
76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY
garment | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James W. Carter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie J. Woodcock | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
216 20 2158 | |
| 17. INFORMANT
James Harrell | | ADDRESS
Millersville Md. | | 236 Severn Road
21108 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Spinal Decubitus
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCVD, Atrial fibrillation | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/23 , 19 87 , to 12/31 , 19 87 , that (I) (we) last saw the deceased alive on 12/31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Latha R Pillai | | | | DEGREE
MD | | 22c. DATE SIGNED
12/31/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PILLAI, LATHA. | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
1/4/88 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | 4001 Ritchie Hwy.
Baltimore Md. 21225 | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1988 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

99

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with the registrar.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages are carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

076595 DEC 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34667
REG. NO.

| | | | | | | | |
|---|--|---|---|---|---------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RANDALL FREELAND | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 24, 1987 | | 2b. HOUR
MIN. SEC.
2:07A | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 01 1917 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
YRS. MONTHS DAYS
70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Rigger | | 12b. KIND OF BUSINESS OR INDUSTRY
Md. Shipbuilders | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Freeland | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl Johnson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II | | 16b. SOCIAL SECURITY NO.
218-09-4462 | |
| 17. INFORMANT
Mrs. Gloria D. Freeland | | 18. ADDRESS
3911 Chatham Rd. Balto. | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Coronary artery disease | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic hypertension | | | |

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 24, 1987 to December 24, 1987 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 24, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | |
| 22b. SIGNATURE
Tawfik Chami M.D. | | 22c. DATE SIGNED
12/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TAWFIK CHAMI M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | |

| | | | | | | | |
|---|--|--------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/29/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Veteran | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. UNDERTAKER
NAME ADDRESS
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | 26. REGISTRAR'S SIGNATURE
[Signature] | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1889-1901

104

DEC 2 1887

REG. NO.

| | | | | | |
|--|--------------------------|--------------------------|---|--------------------------------|--|
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| 13b. STATE | 13c. COUNTY | 13c. CITY OR TOWN | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 21201 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | | | | |
| Mason | Friend | | Foley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(if YES, GIVE WAR OR BRANCH) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | |
| Yes | 231-05-2944 | Barbara Eaton | JOEC | | |

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

423

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

MEDICAL CERTIFICATION

| | | | | | |
|--|-------------------|------------------------------------|-------------------------------|--------|-------|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN | COUNTY | STATE |
| BURIAL | 12-23-87 | GARRISON FOREST V4 | Branta Co. Mo | | |
| 24. FUNERAL DIRECTOR
NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | |
| Joseph L. Pugs | 2232 W. NORTH AVE | DEC 28 1987 | Julia Davidson-Randall | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove your papers. Pages 1 and 2 should be filed with a 72 hours time deposit at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

178337

20% COTTON FIBER

DMO

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 8 7 | | REG NO. 3 4 6 6 9 | | | | | |
| DECEASED NAME (TYPE OR PRINT)
BALLIE E. FRISBY. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/15/87 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
10/10/13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1231 N. Bentall St 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Erastus Wilson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sallie Scarbough | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-05-7745 | | 17. INFORMANT ADDRESS
Betty Johnson 1231 N. Bentall St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest with cardiac arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Sedation to Arterio-sclerotic</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>cardio-vascular with congestive</u>
DUE TO, OR AS A CONSEQUENCE OF } (c) <u>Heart failure.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>pneumonia.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/11/87</u> to <u>12/15/87</u> , that (I) (we) last saw the deceased alive on <u>12/15/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R.M. Shah M.D. | | | | DEGREE | | | | 22c. DATE SIGNED
12/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R.M. SHAH | | | | 22e. ADDRESS
LIBERTY Medical Center
2000 LIBERTY ST AVE. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Nat Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md | | | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1987 | | 25b. REGISTRAR'S SIGNATURE
John Gordon Fordell | | | |

MEDICAL CERTIFICATION

1911

1911

1911

1911

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 6 7 0
REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|---------------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME
(a) FIRST (b) MIDDLE (c) LAST
B Norman Frisch | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/23/87 | | 2b. HOUR
MIN.
12:40 P.M. | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
4/21/19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SNR. CONTROL | | 12b. KIND OF BUSINESS OR INDUSTRY
CROWN-CORR | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
FORK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
21051 12560 Louise Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MARK FRISCH | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Blanch HOBLITZ | | | | ADDRESS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
2200977797 | | 17. INFORMANT
FAMILY RECORDS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Aspiration
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebrovascular Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/23 19 87 to 12/23 19 87 , that (I) (we) lost
saw the deceased alive on 12/23 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
EB George MD, PhD | | | | DEGREE
MD, PhD | | | | 22c. DATE SIGNED
12/23/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EB George | |
| | | | | 22e. ADDRESS
Sinai Hosp. of Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12 28 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FREDERICK MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
EVANS CHAPEL OF MEMORIALS | | | | ADDRESS
8500 HARBOR | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

7000 DEC 21 07

Handwritten notes and tables, mostly illegible due to fading and bleed-through. The text appears to be organized into sections, possibly representing a ledger or a series of calculations. Some visible fragments include:

- Top section: "7000 DEC 21 07" (mirrored from the stamp).
- Middle section: "Handwritten notes and tables, mostly illegible due to fading and bleed-through."
- Bottom section: "Handwritten notes and tables, mostly illegible due to fading and bleed-through."

074439 DEC-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34671
REG. NO.

| | | | | | |
|---|--|--|---|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 3. RELEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| Lillian B. Fritz | | 12-6-87 | | 5:30 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| F | Caucasian | MONTH DAY YEAR | 77 YRS | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MARYLAND | U.S.A. | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | PERRING PKWY. NURSING HOME | HOMEMAKER | HOME | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md | BALTIMORE | BALTIMORE | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 11540 Philadelphia Rd 21162 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| JOSEPH | LUDMILLA | NO | | | |
| 17a. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | |
| 220-01-3639 | PETER P. FRITZ | 4528 OAK RIDGE DR STREET, MD 21154 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Acute myocardial infarction | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) Severe Ischemic Heart Disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| Recent Fracture | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| SPACIA V. DATER | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 12/6/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| SPACIA V. DATER | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| BURIAL | DEC. 9, 1987 | MORELAND MEM. PK. | BALTIMORE COUNTY STATE | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Hartley Miller - 7527 | | DEC 7 1987 | | John Seaton-Hendall | |

W-130 22 11 70

2

1937 Nov 15

030-7-7897

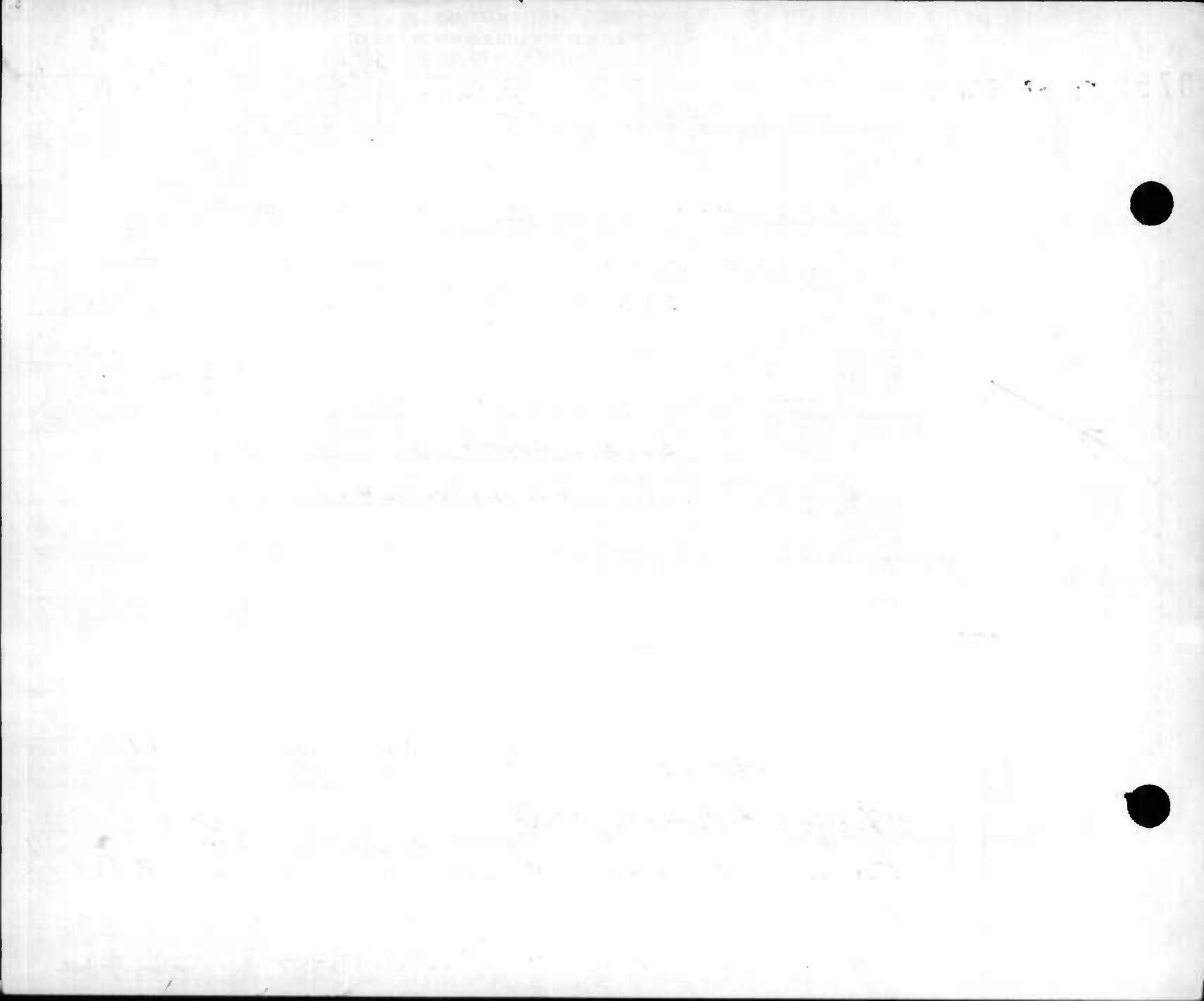
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked ar, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 06 DAY 28 YEAR 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Roanoke, Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4607 Bayonne Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Waitress | | 13a. STREET ADDRESS
4607 Bayonne Avenue | | 13b. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST William MIDDLE Harry LAST Travers | | 15. MOTHER'S MAIDEN NAME
FIRST Nellie MIDDLE May LAST Silvers | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
228-01-6942A | | 17. INFORMANT ADDRESS
Baltimore, Md. 21206
Mrs. Jean Glorioso, 4607 Bayonne Avenue, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe COPD, CHF, Diabetes</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>86</u> , to <u>Dec</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/11/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Theodore K Bonner, MD</u> | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Theodore K Bonner MD</u> | | 22e. ADDRESS
<u>Franklin Square Hosp 9000 Franklin Square D Baltimore</u> | | 22f. REGISTRAR'S SIGNATURE
<u>John Swindon-Randall</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Roanoke Virginia | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | |
| 24. FUNERAL DIRECTOR
NAME
Loring Byers Funeral Directors | | 25b. REGISTRAR'S SIGNATURE
ADDRESS
Randallstown, Md.
8728 Liberty Rd. | | | | | | | |

BP



074845 DEC 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80333132

37 REG. NO. 34673

| | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Albert E Gagne | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 9 87 | | 2b. HOUR
12:05^P | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 20 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Trucking | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Lansdowne | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Artheme Gagne | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary LaMagdeline | | 13e. STREET ADDRESS
21227 | | | 13f. STREET ADDRESS
2201 Hammonds Ferry Rd. Apt. A | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
024-07-5662 | | 17. INFORMANT
ADDRESS
Apt. A 21227
Carol A. Gagne 2201 Hammonds Ferry Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Arteriosclerosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction x3</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Cardiac Arrhythmia</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9/87 to 12/9/87 , that (I) (we) last saw the deceased alive on 12/9/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/9/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
[Signature] | | | | 22e. ADDRESS
St. Agnes Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funereal Home, Inc. | | | | ADDRESS
4107 Wilkens Ave. | | DATE RECEIVED
12/14/87 | | REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2011 2012

10:00 0 37
11:00 0 37
12:00 0 37
13:00 0 37
14:00 0 37
15:00 0 37
16:00 0 37
17:00 0 37
18:00 0 37
19:00 0 37
20:00 0 37
21:00 0 37
22:00 0 37
23:00 0 37
24:00 0 37
25:00 0 37
26:00 0 37
27:00 0 37
28:00 0 37
29:00 0 37
30:00 0 37
31:00 0 37
32:00 0 37
33:00 0 37
34:00 0 37
35:00 0 37
36:00 0 37
37:00 0 37
38:00 0 37
39:00 0 37
40:00 0 37
41:00 0 37
42:00 0 37
43:00 0 37
44:00 0 37
45:00 0 37
46:00 0 37
47:00 0 37
48:00 0 37
49:00 0 37
50:00 0 37
51:00 0 37
52:00 0 37
53:00 0 37
54:00 0 37
55:00 0 37
56:00 0 37
57:00 0 37
58:00 0 37
59:00 0 37
60:00 0 37
61:00 0 37
62:00 0 37
63:00 0 37
64:00 0 37
65:00 0 37
66:00 0 37
67:00 0 37
68:00 0 37
69:00 0 37
70:00 0 37
71:00 0 37
72:00 0 37
73:00 0 37
74:00 0 37
75:00 0 37
76:00 0 37
77:00 0 37
78:00 0 37
79:00 0 37
80:00 0 37
81:00 0 37
82:00 0 37
83:00 0 37
84:00 0 37
85:00 0 37
86:00 0 37
87:00 0 37
88:00 0 37
89:00 0 37
90:00 0 37
91:00 0 37
92:00 0 37
93:00 0 37
94:00 0 37
95:00 0 37
96:00 0 37
97:00 0 37
98:00 0 37
99:00 0 37
100:00 0 37

73611 DEC-287

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL H.
CERTIFICATE OF DEATH87 34674
REG. NO.

| | | | | | |
|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Jeannette A Gaines | | | 2a. DATE OF DEATH
MONTH 12 DAY 1 YEAR 87 7:20 A.M. | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 3 DAY 14 YEAR 4 | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | 7b. HOURS 7:20 MIN. A.M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. STREET ADDRESS
524 N. Charles St.
21201 | | |
| 14. FATHER'S NAME
FIRST George MIDDLE Pickett LAST Pickett | | 15. MOTHER'S MAIDEN NAME
FIRST Alice MIDDLE Fox LAST Fox | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
202-30-5575 | | 17. INFORMANT Alice Read, 308 W. Lanvale St.
Balto., Md. 21217 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Pancreatic Carcinoma (probable)
DUE TO, OR AS A CONSEQUENCE OF
(c) Congestive Heart Failure, Sepsis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
probable dx on admission 11/24/87 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Congestive Heart Failure, Sepsis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/24 , 19 87 , to 12/1 , 19 87 , that (I) (we) lost
saw the deceased alive on 11/1/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/1/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kovitz | | 22e. ADDRESS
University of Maryland Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE) Burial | | 23b. DATE
DEC. 4, 1987 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hanover Twp., Luzerne, PA |
| 24. FUNERAL DIRECTOR
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Baltimore, Md. 21214 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 01 1987 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or at the medical examiner must be notified at once.

BP

22 NOV 6 1947

RECEIVED

NOV 22 1947

075917 DEC 23 1987

FOR
SITE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4675

| | | | | | | | |
|--|--|--|---|---|--|---|-------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR |
| Nettie | | S. | | Gaines | 12/ 18/ 19 87 | | M |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE
PRONOUNCED
DEAD | 7d. HOUR |
| FEMALE | BLACK | 3 23 1897 | | 90 | | 12/ 18/ 19 87 | 7:55
a M |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MARYLAND | U. S. A. | | | | Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | |
| Baltimore | 2500 Hollins St. | | DOMESTIC | | PVT. FAMILY | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | | |
| MARYLAND | | BALTIMORE | | | BALTIMORE, MD.
2500 HOLLINS ST. 21223 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| FREDERICK | | SAWLES | | JULIA BRISCOE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| NO | | 213-20-5837A | | MRS. BALTIMORE, MD. 21217
EDITH BEAN 2033 N. FULTON AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL
SIGNATURE | | Dennis F. Smyth, M.D. | | | | DATE
SIGNED 12/18/87 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | 111 Penn St., Balto., Md. 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| BURIAL | | 12/22/1987 | ARBUTUS MEMORIAL PK. | | BALTIMORE, MD. | | |
| 24. FUNERAL HOME
(NAME AND ADDRESS) | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| WYNNE FUNERAL HOMES, INC,
2501 GWYNNS FALLS PKWY, BALTO, MD, 21216 | | DEC 22 1987 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM EN-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

0580177030

100% COTTON TUBES

WYLLIAMS



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 4 6 7 6
REG. NO.

075828 DEC 22 1987

FOR
1. STATE
REGISTRAR

2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Ahmad DIMETRIUS Galloway

20. DATE OF DEATH

MONTH

DAY

YEAR

12/17/87

26. HOUR

052 am

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

MONTH

DAY

YEAR

05 01 87

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

YRS.

7 16

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Baltimore

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Bal to

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Univ. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)

infant

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

MD

13c. CITY OR TOWN

BALTO

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2912 Southland Ave

14. FATHER'S NAME

Wallace

MIDDLE

Galloway

15. MOTHER'S MAIDEN NAME

Belinda

MIDDLE

Fuller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

none

16b. SOCIAL SECURITY NO.

none

17. INFORMANT

Terry L Jarrett MD Univ. H

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

respiratory failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10/8 F

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

pneumocystis

pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

AIDS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/14, 19 87, to 12/17, 19 87; that (I) (we) last saw the deceased alive on 12/17, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Terry L Jarrett MD

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

12/17

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Terry L Jarrett

22e. ADDRESS

Univ. Hosp.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-21-87

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DEC 21 1987

24. FUNERAL DIRECTOR

NAME

Calvin B. Scruggs

ADDRESS

1412 Preston ST

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DEC 21 1987

[Faint, illegible text, likely bleed-through from the reverse side of the page]

075431 DEC 10 07

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 34677
REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|---|----------------------------|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(Type or Print)
FIRST MIDDLE LAST
<u>Irving O. GALPERIN</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>12-14-87</u> | | 2b. HOUR
<u>7:35 PM</u> | | | | | | | | |
| 3. SEX
<u>M</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>5 16 11</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>76</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Baltimore, Md</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Levindale Geriatric</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Pharmacist</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>DRUG</u> | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE <u>md</u> 13c. COUNTY <u>BALTIMORE</u> 13d. CITY OR TOWN <u>BALTIMORE</u> 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS / ZIP CODE
<u>3301 Charles Lane 21215</u> | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Samuel Galperin</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Sarah Unknown</u> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>212-07-8076</u> | | 17. INFORMANT
<u>Gloria Galperin</u> | | | | ADDRESS
<u>3301 Clarks La Aptc</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>INABILITY TO SWALLOW</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>END-STAGE PARKINSONS</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 Days</u>
<u>MONTHS</u>
<u>Years</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Dementia</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>—</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>—</u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>—</u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<u>—</u> | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u>—</u> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<u>—</u> | | | | | | | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>4-3-87</u> to <u>12-14</u> 19 <u>87</u> , that (I) <u>we</u> lost saw the deceased alive on <u>12-14</u> 19 <u>87</u> , and that in <u>my</u> (your) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>A. J. Lucco</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12-15-87</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>A. J. Lucco, MD</u> | | | | 22e. ADDRESS
<u>2434 W. Belvue Ave BALTO 21215-5299</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>12/16/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Hebrew</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Reisterstown BALTO MD.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>Hebrew Memorial F.H. INC-1100 Reisterstown Rd</u> | | | | 25a. DATE REC'D BY REGISTRAR
<u>DEC 17 1987</u> | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director. Page 3 should be detached for use at the burial. Please remove carbon copies. Properly filled out, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or either if domestic violence or sexual abuse is indicated, it must be reported to the police.)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED BY THE DIRECTOR

NOV 11 1967

10-41-67

075 109 DEC 15 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 3 4 6 7 8
REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DEANDREA GARDNER | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 5, 1987 | | 2b. HOUR
A
1:15 M | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 6 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEWCASTLE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 13a. STATE
DE | | 13b. COUNTY
NEWCASTLE | | 13c. CITY OR TOWN
99999 | |
| 14. FATHER'S NAME
DEANDREA | | 15. MOTHER'S MAIDEN NAME
COTANYA R. GARDNER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
SANDRA J. GARDNER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>RESPIRATORY/RENAL FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CONGENITAL HEART DISEASE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MINS.
~ 2 WEEKS
LIFETIME | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | |
| 19a. DATE OF OPERATION
10/22/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
AV canal, single Atrium, PDA
Anomalous pulmonary vein | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/21 19 87, to 12/5 19 87, that (I) (we) last saw the deceased alive on 12/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
PCarlson | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P CASLOWITZ | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL 21205 BALTIMORE MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12-10-87 | | 23c. NAME OF CEMETERY OR CREMATORY
RIVERVIEW CEMETERY | |
| 23d. LOCATION
WILMINGTON NEWCASTLE | | STATE
DE | | | |
| 24. FUNERAL DIRECTOR
NAME
Vaughn Green | | ADDRESS
10 Laurens St. | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
P. C. Rindell | |

MEDICAL CERTIFICATION

COPIES
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked question 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.
999999
DHMH - 16 50M 1/81 (VRA 15, 4)



076580 DEC 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 34679

| | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James R. Garner | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 23 87 | | | 2b. HOUR
12:15 AM | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 4 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unknown | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1301 Kuper St 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary C. Cox | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unknown | | | 16b. SOCIAL SECURITY NO.
23-910-2843 | | 17. INFORMANT
ADDRESS
Phyllis Belsky 1301 Kuper St. Balt MD 21223 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardio pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) Aneurysm / Cerebral bleed | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour
3 hours
Indeterminate | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Peripheral vascular Disease, CVA | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15, 19 87, to 12/23, 19 87, that (I) (we) last saw the deceased alive on 12/23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
R. Dart | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/23/87 | | 22d. ADDRESS
3001 S. Kenner St., Balt. MD | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Dart | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
12-23-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, Maryland 21228 | | | |
| 24. FUNERAL DIRECTOR
Gary L. Kaufman Funeral Home 5695 Main St.
Elkridge, Maryland 21227 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1987 | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
Julia E. Gordon-Randall | | | | | |

MEDICAL CERTIFICATION

99

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

25225 Maryland, Maryland 25225

25225 Maryland, Maryland 25225

12-1-57

Operation


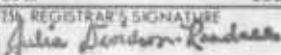
Only 1. 25225 Maryland 25225
25225 Maryland 25225

DEC 2 9 1957

074787 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 6 8 1
REG NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Robert L. Garris | | | | | | 2a. DATE KNOWN OF DEATH
EST. <input checked="" type="checkbox"/> MONTH 12 DAY 9 YEAR 1987 | | 2b. HOUR 4:45P | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH 6 DAY 24 YEAR 53 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 34 YRS. | | 7. IF UNDER 1 YR. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4355 Robertson Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
MORD CRAFT INC. | |
| 12b. KIND OF BUSINESS OR INDUSTRY
FULLTIME | | 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE | | | | | | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4355 ROBERTSON AVENUE 21206 | | | | | | | |
| 14. FATHER'S NAME
FIRST ROBERT MIDDLE LEE LAST BROWN | | | | 15. MOTHER'S MAIDEN NAME
FIRST VICTORIA MIDDLE GARRIS LAST GARRIS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR (UNKNOWN))
NO | | | | 16b. SOCIAL SECURITY NO.
214-62-6941 | | 17. INFORMANT
ROBIN GARRIS 4355 ROBERTSON AVENUE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 10 PART 1 OR PART 2)
Subject inhaled fumes from auto | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET 4355 Robertson avenue, Baltimore City, MD | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED 12-10-87 | |
| EXAMINER'S NAME
(TYPE OR PRINT) Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn Street, Baltimore, MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
12/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY | | 23d. LOCATION
CITY OR TOWN BALTIMORE COUNTY MD | |
| 24. FUNERAL DIRECTOR
NAME WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1987 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25A

BP
DHMH - 17
(VR A15 ME (5))

724 331 727 70

DEC 11 1987

076974 JAN -5

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 34682

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FREDERICK N. Gaskins, Sr | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 87 | | 2b. HOUR
0445^{AM} | | | | | |
| 3. SEX
M | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 27 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. STATE
MD | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Balt. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3409 Royce Ave 21208 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Teter Gaskins | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kate Newton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217 09 5822 | | | 17. INFORMANT
Ellen Gaskins | | | ADDRESS
3409 Royce Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multi-system failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (his/hospital) attended the deceased from 12/16 , 19 87 to 12/30 , 19 87 , that (I) (we) last saw the deceased alive on 12/30 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Roxanne S. Donovan | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/30/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROXANNE S DONOVAN | | | | | | 22e. ADDRESS
Sinai Hosp. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1/4/88 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H West | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1988 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confederators. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

1. The first step in the process of standardization is the selection of a representative sample of the population to be studied. This sample should be chosen in such a way that it is representative of the entire population in all respects except the one being studied. The sample should be large enough to give reliable results, but not so large that the cost of the study becomes prohibitive. The sample should be chosen in such a way that it is representative of the entire population in all respects except the one being studied.

2. The second step in the process of standardization is the selection of a representative sample of the population to be studied. This sample should be chosen in such a way that it is representative of the entire population in all respects except the one being studied. The sample should be large enough to give reliable results, but not so large that the cost of the study becomes prohibitive. The sample should be chosen in such a way that it is representative of the entire population in all respects except the one being studied.

3. The third step in the process of standardization is the selection of a representative sample of the population to be studied. This sample should be chosen in such a way that it is representative of the entire population in all respects except the one being studied. The sample should be large enough to give reliable results, but not so large that the cost of the study becomes prohibitive. The sample should be chosen in such a way that it is representative of the entire population in all respects except the one being studied.

074069 DEC - 3 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 6 8 3

| | | | |
|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Mary</u> MIDDLE <u>Ann</u> LAST <u>George</u>
MARY ANN GEORGE | | 2a. DATE OF DEATH
MONTH <u>12</u> DAY <u>1</u> YEAR <u>87</u>
2b. HOUR <u>1240</u> AM | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH <u>July</u> DAY <u>22</u> YEAR <u>1928</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS
IF UNDER 1 YEAR: MONTHS <u> </u> DAYS <u> </u> IF UNDER 24 HRS: HOURS <u> </u> MIN. <u> </u> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Penna. | | 13b. CITY OR TOWN
Johnstown | |
| 13c. STREET ADDRESS
135 Spring St., | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>George</u> MIDDLE <u> </u> LAST <u>Goch</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Mary</u> MIDDLE <u> </u> LAST <u>Bresnickey</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
210-09-0542 | |
| 17. INFORMANT
Pat Petak (daughter) | | ADDRESS
135 Spring St. Johnstown, PA | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE ORGAN FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYELOGENOUS LEUKEMIA
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> </u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u> </u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR <u> </u> A.M. MONTH <u> </u> DAY <u> </u> YEAR <u> </u>
P.M. <u> </u> 19 <u> </u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET <u> </u> CITY OR TOWN <u> </u> COUNTY <u> </u> STATE <u> </u> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>87</u> , to <u>12/1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Flavio Kruter</u> | DEGREE
<u> </u> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
<u>12/1/87</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FLAVIO KRUTER | | 22e. ADDRESS
22 SOUTH GREENE | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
4 Dec. 87 | 23c. NAME OF CEMETERY OR CREMATORY
Grandview Cemetery | 23d. LOCATION
CITY OR TOWN <u>Johnstown</u> , COUNTY <u>Penn.</u> STATE <u> </u> |
| 24. FUNERAL DIRECTOR
NAME
Capitol Funeral Service, Falls Church, VA | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 03 1987</u> REGISTRAR'S SIGNATURE <u>John Davidson-Baker</u> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

07401 1-2-21

George and Mary

George and Mary
July 22, 1900

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

University Hospital
U.S.A.

076247 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 3 4 6 8 4
REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Leonard George Getschel | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 14 87 | | 2b. HOUR
9:30 PM |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 29, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Banker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dr. John Leonard Getschel | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Johanna Kalbfleisch | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
213 10 3636 A | | 17. INFORMANT
ADDRESS
Mr. Bruce Sawyer 201 Longwood Rd. 21210 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) BONE MARROW FAILURE | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/7 , 19 87 , to 12/14 , 19 87 , that (I) (we) last saw the deceased alive on 12/14 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Eric Schleikorn, M.D. | | | | 22c. DATE SIGNED
12/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERIC SCHLEIKORN, M.D. | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1987 | |

MEDICAL CERTIFICATION

35
44
35
3009
9

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0162 12301

SECTION-FIFTEEN

Page 1 of 1

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

1971

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 6 8 5

FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Harry C. Gianakos | | | 2a. DATE OF DEATH
MONTH DAY YEAR
November 13, 1987 | | 2b. HOUR
7:42P_M | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 15 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
64 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mater D Maitred Restaurant | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gus N. Gianakos | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Stella Vrettakos | | 13e. STREET ADDRESS / ZIP CODE
2 Dwelling House Ct. 21228 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes W.W.11 | | 16b. SOCIAL SECURITY NO.
228-16-9713 | | 17. INFORMANT
Mr. John C. Gianakos | | ADDRESS
Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 minutes | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Respiratory Arrest | | | | | | 10 minutes | |
| (c) pneumonia | | | | | | 10 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Cardiomyopathy with Ejection fraction - 20 percent, status/post open lung biopsy | | | | | | | |
| 19a. DATE OF OPERATION
November 3, 1987 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
lung mass of unknown etiology | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 28, 1987 to November 13, 1987 , that (I) (we) lost saw the deceased alive on November 13, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Gregory P. Midis | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gregory P. Midis | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
11/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Monticello Memory Gdns | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Charlottesville Va. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. 1050 York Rd, | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 16 1987 | | 25b. REGISTRAR'S SIGNATURE
John Linder-Pandora | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

75137 NOV 1961

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---------------------------------------|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Amelia F. Gier | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 31, 1987 | | | | | 2b. HOUR
M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
May 27, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Meridian Hamilton Nursing Home | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3010 Roselawn Avenue 21214 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Adolph Weigand | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Amelia | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
218-68-1622 | | 17. INFORMANT ADDRESS
Mrs. Jeanette Palmere 5809 Sefton Avenue | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY INSUFFICIENCY
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 05 02 19 86 to 12-18 19 87 , that (I) (we) last saw the deceased alive on 12-18 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) laid (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Cesar G. Gamboa MD DEGREE | | | | | | | | 22c. DATE SIGNED
1-4-88 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Cesar G. Gamboa MD | | | | | | | | 22e. ADDRESS
3440 Belair Road Baltimore, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Jan. 4, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D BY REGISTRAR
JAN 5 1988 | | 25b. REGISTRAR'S SIGNATURE | | | | |

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "January" and "1952" are faintly visible.]

076364 DEC 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 6 8 7
REG. NO.

| | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF ESTI.
DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR | |
| Agnes | | V. | | Gill | | | | 12-20 19 87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE
PRONOUNCED
DEAD | | 2d. HOUR | |
| Female | White | Sept 21 1931 | | 56 YRS. | | | | 12-21 19 87 | | 8:25 p. M | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City, | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS | | | |
| Baltimore | | 2711 Beechland Avenue | | | | Bookkeeper | | Construction
Gen Supply | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Maryland | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2711 Beechland Ave 21214 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| Joseph W. Gill | | | | Agnes I Hilton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 213-26-6357 | | Shirley M. Mills | | Balto Md 21225
817 Clintwood Court | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>Obesity</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held them until death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | TITLE (SPECIFY)
Assistant | | | | DATE
SIGNED 12-22-87 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Charles P. Kokes, M.D. | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 12/24/87 | | Cedar Hill Cemetery | | Baltimore A.A. Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | DEC 28 1987 | | Julia T. [Signature] | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FCIM 11A. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))

07834 10000

2 1931 12 20

0000000000

0000000000

0000000000

0000000000

0000000000

0000000000

0000000000

0000000000

0000000000

0000000000

077440 JAN 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, prior to final disposition, or removal.

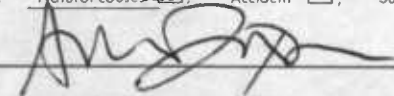
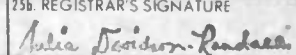
IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARGARET GILL | | | | | | | | | |
| 2a. DATE OF DEATH MONTH DAY YEAR
12 / 28 / 87 | | 2b. HOUR PM
1220M | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
April 2, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
93 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3900 N. Charles St. 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Karfgin | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Gertrude Esselman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-20-6561 | | 17. INFORMANT ADDRESS
Earl G. Gill, Jr. Balto., Md. 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
72 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE
Union Memorial Hospital | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 26 , 19 87 , to December 28 , 19 87 , that (I) (we) last saw the deceased alive on December 28 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Patricia Kelly MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Patricia Kelly MD | | | | 22e. ADDRESS
Union Memorial Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 31, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Parkville, Balto. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1988 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

3 4 6 8 9
REG. NO.

| | | | | | |
|--|-------------------------|--|---|---|--------------------------------|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (FIRST MIDDLE LAST)
VIRGINIA M. GILLOOLY | | MONTH DAY YEAR
12 12 87 | | M
87 | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH (MONTH DAY YEAR)
June 7, 1917 | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1772 Homestead St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)
Manly H. Jones | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Sarah N. Johnson | | 16. ADDRESS
Shrewsbury, Pa. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
216-03-0935 | | 17. INFORMANT
Mr. James P. Gillooly 643 Main St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
Deputy Chief | | DATE SIGNED
12-16-87 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St., Balto., MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 19, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc, Baltimore, Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
 | |

075421 DEC 18 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

70 01 200 1 2 1 2 7 0

CF 1997, 7, 1001.

[illegible]

events in

• **Disadvantages:**

0000,

— 70 —

C

Index 6-0781.1.99

Table 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, death, or traumatic event, the medical examiner must be notified of same.)

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34690

1. FOR
STATE
REGISTRAR

Estelle L. Goebel

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Estelle

Goebel

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
December 12 1987 3:32 A.M.

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

MONTH DAY YEAR 12 12 09

6. AGE (IN YEARS LAST BIRTHDAY)

75 YRS.

IF UNDER 1 YEAR IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Joseph Richey House

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

JAMES PERSON

12b. KIND OF BUSINESS OR INDUSTRY

Dept. Store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD

13b. COUNTY Harford

13c. CITY OR TOWN Forest Hill

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS

1610 Michelle Court 21050

14. FATHER'S NAME

HIRAM

MIDDLE

5th

15. MOTHER'S MAIDEN NAME

MARY

MIDDLE

Schmalin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

216-36-6039

17. INFORMANT 25. Battersea Bridge Ct.

Patricia Roberts (dgntr)

Lutherville, Md.

21050

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE Cause (a)

CARDIORESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) CANCER OF THE LUNG

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from DEC. 23, 1987, to DEC. 12, 1987, that (I) (we) last saw the deceased alive on DEC. 12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

L.M. Juranmoy

DEGREE

M.D.

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

12/14/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

L.M. Juranmoy M.D.

22e. ADDRESS

100 N. BROADWAY, BALD. MD. 21231

23a. BURIAL, CREMATION, REMOVAL

BURIAL

23b. DATE

12/14/87

23c. NAME OF CEMETERY OR CREMATORY

OAK LAWN

23d. LOCATION

CITY OR TOWN BALTIMORE

COUNTY

STATE MD.

24. FUNERAL HOME

SCHIMMONEK FUNERAL HOME, INC.

9705 Belair Rd.

Balto. Md. 21236

25a. DATE REC'D. BY REGISTRAR

DEC 15 1987

25b. REGISTRAR'S SIGNATURE

Julia Roberts

075123 DEC 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 34691

| | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|---------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HENRY | | | 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 17 1896 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
91
YRS | | | 7a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 8 1987 | | | 7b. HOUR
7:30 P. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3323 DUDLEY AVENUE | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TRAFFIC OFFICER | | | 12b. KIND OF BUSINESS OR INDUSTRY
BALTO. CITY POLICE DEPT. | | | | | | | | |
| 13a. STATE
MD. | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
3323 DUDLEY AVENUE 21213 | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FREDERICK GOETZKE | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA HOFFMAN | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW I 213-32-1600A | | | 17. INFORMANT ADDRESS
MARY GOETZKE (WIFE) SAME ADDRESS | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mo. | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Transient ischemic attacks | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 15, 1987, to Dec 8, 1987, that (I) (we) last saw the deceased alive on July 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Donald Jandorf M.D. | | | | | | 22c. DATE SIGNED
12-9-87 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. DONALD JANDORF | | | | | | 22e. ADDRESS
7403 HARFORD RD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
12-12-87 | | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | | | | | | | | | |
| 24. FUNERAL HOME
SCOTT'S FUNERAL HOME, INC. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | | | 25b. REGISTRAR'S SIGNATURE
Julia [Signature] | | | | | | | | | | | |
| 26. ADDRESS
3331 BREMS LANE
BALTO. MD. 21213 | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



BP

DHMH - 16 60M 7/84
(VRA 15, 4)FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 4 6 9 2
REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
David - Goldstein | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 87 | | | 2b. HOUR
12 AM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 28 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
LEVINDALE GERIATRIC HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
PUBLIC SERVICE | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN PIKESVILLE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 33 STONEHENGE CIRCLE APT. 4 #21208 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HYMAN GOLDSTEIN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESTHER COHEN (21208) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-18-7088 | | 17. INFORMANT ADDRESS
MRS. DORIS Z. GOLDSTEIN 33 STONEHENGE CIRCLE APT. 4 (21208) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POSSIBLE ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 12/12/87 to 12/13/87, that (we) last saw the deceased alive on 12/12/87, and that (our) opinion death occurred on the date and hour and from the causes stated above. (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
ESTRELLITA O. KIM | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ESTRELLITA O. KIM | | | | 22e. ADDRESS
LEVINDALE GERIATRIC CENTER - HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/13/87 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH TFILOH CONG. | | 23d. LOCATION
WOODLAWN, BALTO., MD. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS.
6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Dindon-Rodriguez | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for additional information.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

75223 DEC 16 1987

15-00000

CONFIDENTIAL
EXCLUDED FROM AUTOMATIC DOWNGRADING AND DECLASSIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| MARTHA | | S. | | GOMBERG | | December 7, 1987 | | 1440 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | JUNE 16, 1897 | | 90 YRS | | MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| AUSTRIA | | USA | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | | | ATTORNEY | | AT LAW | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5906 PARK HTS AVE. #21215 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| JOSEPH | | ROSE | | LEVY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | 286-07-4109 | | MRS. JOANNE G. NATHANS | | | | | |
| | | | | 2227 CREST RD. BALTO., MD 21209 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Overwhelming Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Dementia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (we) (this hospital) attended the deceased from <u>Dec 5</u> 19 <u>87</u> to <u>Dec 7</u> 19 <u>87</u> , that (I) (we) (last saw the deceased) (live on) <u>Dec 7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>Scott Rifkin</u> | | MD | | | | 12/7/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| SCOTT RIFKIN, M.D. | | UNION MEMORIAL HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | |
| CREMATION | | DEC. 8, 1987 | | LOUDON PARK | | BALTIMORE | | MARYLAND | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| SOL LEVINSON & BROS., INC. | | DEC 15 1987 | | <u>Julia D. R. Rader</u> | | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD | | 21215 | | | | | | | |

BP

072502 DEC 1967

OLIO 4

4

4

4

4

4

UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

DEC 19 1967

077485 JAN-7-88

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 34694

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Ethel W. Goodman</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 31 87</i> | | 2b. HOUR
<i>9:58 AM</i> |
| 3. SEX
<i>female</i> | 4. RACE
<i>Caucasian</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>10 1 02</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>85</i> | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>CITY OF BALTIMORE</i> MD | |
| 10. CITY OR TOWN OF DEATH
<i>Balto</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Sinai Hosp. of Balto</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>AT HOME</i> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>MARYLAND</i> 13b. COUNTY <i>BALTIMORE</i> 13c. CITY OR TOWN <i>BALTIMORE</i> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>JOSEPH WEINBERG</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>RAE UNKNOWN</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>212-09-8945</i> | | 17. INFORMANT
<i>LAWRENCEVILLE, N.J.</i>
<i>MARGARET HUCHET 2 MILLBROOK LANE 08648</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Resp Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Sepsis</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/22</i> , 19 <i>87</i> , to <i>12/31</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Eric Weiner</i> | | | | 22c. DATE SIGNED
<i>12/31/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Eric Weiner</i> | | | | 22e. ADDRESS
<i>Sinai Hosp. of Balto</i> | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>BURIAL</i> | | 23b. DATE
<i>1/1/88</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>BALTO HEBREW CEM BALTIMORE</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTIMORE MD</i> | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>SOL LEVINSON & BROS., INC.</i>
<i>6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | | 25. REGISTRAR'S SIGNATURE
<i>JAN 6 1988</i> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

BP

607-1

84750

WILSON
FIBER
CORP.

076147 DEC 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

34695
REG. NO.

| | | | | | |
|--|---|--|--|---|---|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | DATE ESTIMATED | | MONTH DAY YEAR | |
| Louise Goodman | | 12/ 20/ 19 87 | | M | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Female | Black | 10-1-23 | 64 | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| South Carolina | USA | | | Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | 4010 Hayward Ave. | unemployed | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | |
| Md. | | Baltimore | | 4010 Hayward Ave. 21215 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| Dudley Goodman | | | Ella Windom | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | |
| no | | 219-22-4638 | | Elma Goodman 1626 E. 30th St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | |
| (b) _____ | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| <i>Dennis F. Smyth</i> | | Assistant | | 12/21/87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Dennis F. Smyth, M.D. | | 111 Penn St., Balto., Md. 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 12-24-87 | King Mem. Pk. | | Balto. Md. |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| <i>Carlton C. Daughan</i> | | 1701 McCulloch St. | | DEC 24 1987 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

W07090-9-1-57!

100-442887-100

076982 JAN 15 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit from the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4696

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
AKA FIRST <u>2</u> <u>FRANCIS</u> MIDDLE <u>R.</u> LAST <u>GOSTOMSKI</u> | | 2a. DATE OF DEATH
MONTH <u>12</u> DAY <u>29</u> YEAR <u>87</u> | | 2b. HOUR
<u>12:22AM</u> | |
| 3. SEX
<u>Male</u> | 4. RACE
<u>Caucasian</u> | 5. DATE OF BIRTH
MONTH <u>2</u> DAY <u>27</u> YEAR <u>31</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>56</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MD</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore CITY</u> MD | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>South-Balt. Gen. Hosp</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Fork lift operator</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>ROOFING</u> |
| 13a. STATE
<u>MD</u> | | 13b. COUNTY
<u>=====</u> | 13c. CITY OR TOWN
<u>Baltimore</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>Frank</u> MIDDLE <u></u> LAST <u>Gostomski</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Bertha</u> MIDDLE <u></u> LAST <u>DeChriste</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>Yes</u> (IF YES, GIVE WAR OR DATES) <u>Korean</u> | |
| 16b. SOCIAL SECURITY NO.
<u>212284352</u> | | 17. INFORMANT
<u>Abra Gostomski</u> ADDRESS <u>1019 Church St. Balt.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> <u>Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>CVA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pneumonia</u> <u>Bowel infarction</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 minutes</u>
<u>12 hours</u>
<u>2 days</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>87</u> , to <u>12/29</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>R. Dart</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>12/29/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Robert Dart</u> | | 22e. ADDRESS
<u>3001 S. Hanover St. Balt 21230</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Cremation</u> | | 23b. DATE
<u>12/30/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Westview Memorial Park</u> | |
| 23d. LOCATION
CITY OR TOWN
<u>Catonsville</u> | | COUNTY
<u>Balto</u> | | STATE
<u>Md</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>George J. Gonce</u> ADDRESS
<u>4001 Ritchie Hwy Balto Md</u> | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |

BP

JAN 4 1988

05C003 11-200

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "SECTION" and "TABLE" are visible.]

[Faint text at the bottom of the page, possibly a footer or additional notes.]

075131 DEC 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34697

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Sylvester J. Graham | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/12/87 | | | 2b. HOUR
12:30 AM | |
| 3. SEX
M | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 17 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
No Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Md. Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willie Graham | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena James | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
245-18-0739 | | 17. INFORMANT
ADDRESS
medical record | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cachexia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
— |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> , 19 <u>87</u> , to <u>12/12</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A.W. Dromerick MD | | | | DEGREE | | 22c. DATE SIGNED
12/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.W. Dromerick MD | | | | 22e. ADDRESS
Univ. of Md Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

NOV 19 1931

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Dear Sir" and "Yours faithfully" are faintly visible.]

DEC 12 1931

075107 DEC 15 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The following certifies that the death certificate was executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 4 6 9 8

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FLOYD GRAVES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 07 87 | | 2b. HOUR
5:15 PM |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
12 08 21 | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD | | |
| 10. CITY OR TOWN OF DEATH
BALT | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven VA | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
BETH. STEEL |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO. | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
2682 GATEHOUSE DR. 21207 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAM FLOYD GRAVES | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JULIA BELL GRAVES | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT ADDRESS
CARRIE L. SMELLY RT. 3 BOX 919 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>87</u> , to <u>12/7</u> , 19 <u>87</u> , that (I) <u>we</u> saw the deceased alive on <u>12/7</u> , 19 <u>87</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>B. Pichney MD</u> | | DEGREE | | 22c. DATE SIGNED
<u>12/7/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PICHNEY MD | | 22e. ADDRESS
Loch Raven VA Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/14/87 | 23c. NAME OF CEMETERY OR CREMATORY
ALLEN CHAPEL CEM. | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
BURLINGTON, N.C. <u>North Carolina</u> | |
| 24. FUNERAL DIRECTOR
NAME
LEROY O. DYETT 4600 LIBERTY HEIGHTS AV | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1987 | | 25b. REGISTRAR'S SIGNATURE | |

05210 11221

MAINTENANCE

RECEIVED